FOX PEDIATRICS, PLC

CONSENT FOR MEDICAL TREATMENT OF A MINOR OR DEPENDANT

I hereby state and authorize that I am the parent of:

______________________________ PATIENTS NAME - printed ______________________________ Date of Birth

I authorize this child to receive medical treatment from Fox Pediatrics, PLC. I consent to the performance of such medical treatment and procedures, which are medically necessary or advisable. This includes, but is not limited to, treatment to relieve pain.

I authorize the person(s) listed below to seek such medical treatment for my child in my absence.

____
Name

______________________________ ______________________________
Relationship Phone

____
Name

______________________________ ______________________________
Relationship Phone

I agree that I am financially responsible for the service(s) provided. A photocopy of this authorization shall be deemed effective as if it were an original. This authorization shall remain in effect for one year from the date it is signed.

______________________________ ______________________________
Parent Name - PRINTED DATE

______________________________ ______________________________
Parent Name - SIGNED DATE