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## **Permission to Treat**

(Print name(s) of legal guardian(s)	authorize Dr. Diaz Pediatrics and its personnel to
(Print name(s) of legal guardian(s) deliver medical services to my child(rea	n).
deriver medical services to my emiditer	u <i>y</i> .
21.17.1	
Print child's name and DOB	
I (We) authorize the following people to	o bring my child in for treatment:
Name:	Relationship:
	Relationship:
Name:	Relationship:
Name:	Relationship:
Signature of legal Guardian	Date
organization of regar Guardian	Date
Relationship to patient:	