



GENTLE PEDIATRICS

DELEGATION OF CONSENT

PATIENT NAME _____ DOB _____

I hereby authorize the following individual(s) to bring my child to GENTLE PEDIATRICS for obtaining any or all medical/surgical/laboratory care.

NAME OF INDIVIDUAL

RELATIONSHIP TO CHILD

NAME OF INDIVIDUAL

RELATIONSHIP TO CHILD

NAME OF INDIVIDUAL

RELATIONSHIP TO CHILD

NAME OF INDIVIDUAL

RELATIONSHIP TO CHILD

This authorization is intended to remain in full force and effect until terminated by me in writing.

Name of Parent/Legal guardian _____

Relationship to child _____

Signature _____

Date _____