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 ____