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 _____