

**CONSENT FOR TREATMENT**

**Patient's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

I give \_\_\_\_\_ authorization to  
(Name of person bringing patient & relation to patient)

**bring my child/children to Henry County Pediatrics, LLC for treatment.**

\_\_\_\_\_  
**(Parent's Name Printed)**

\_\_\_\_\_  
**(Parent's Signature)**

\_\_\_\_\_  
**(Date)**