COLUMBIA PEDIATRICS
MEDICAL GROUP, INC.
www.columbiapediatrics.com

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Authorization to Treat Minor Children

I hereby consent to and authorize the physicians at Columbia Pediatrics Medical Group, Inc., to examine and render treatment to my minor child at any time it is deemed medically necessary. This authorization shall remain valid for all Columbia Pediatrics medical encounters unless otherwise instructed by me, the parent/legal guardian.

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Child/Patient's Name (print clearly) **Child/Patient's Birthdate**

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Parent/Guardian Name (print clearly) **Relationship to Patient**

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Witness

I also give permission to the following adult family members and/or caregivers to authorize medical care and treatment on my behalf in the event I cannot personally accompany my child. I can revoke this permission at any time by *crossing out the name, dating and initialing next to it.*

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Parent/Guardian Signature **Date of Signature**