Consent to Treat

Dr. Anne! Modern Parenting, Classic Healthcare.
www.DrAnneMD.com

I hereby authorize Anne Georgulas, M.D. and staff to treat the patients named below.

First Name	Last Name	MI	DOB
			/ /
			/ /
			/ /
			/ /
			/ /
			/ /

Signed: _____ Date _____
Parent or Legal Guardian

Transfer of Consent to Another Party

I hereby authorize the following persons to bring my child for medical attention. I consent to treatment in my absence.

First Name	Last Name	MI	DOB
			/ /
			/ /
			/ /

Signed: _____ Date _____
Parent or Legal Guardian

Consent for Teenage Child to Seek Treatment

I hereby authorize my teenage child to consent to treatment in my absence.

Signed: _____ Date _____
Parent or Legal Guardian

Release of Information (including lab results)

I hereby authorize the following persons to receive by verbal or written statement information related to the medical condition of the patients named above.

First Name	Last Name	MI	DOB
			/ /
			/ /
			/ /

Signed: _____ Date _____
Parent or Legal Guardian

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