STEPPING STONES PEDIATRIC AND ADOLESCENT MEDICINE
CONSENT TO TREAT FORM

I hereby authorize employees and agents of Stepping Stones Pediatric and Adolescent Medicine including physicians and other staff members to render medical evaluation and treatment to the patient(s) listed below. The duration of this consent is indefinite and will continue until revoked in writing. I understand that by not signing this consent, the patient(s) listed below will not be provided medical care except in the case of an emergency.

_____		_____	
Patient Name	Date of Birth	Patient Name	Date of Birth
_____		_____	
Patient Name	Date of Birth	Patient Name	Date of Birth

Signed:_____
Signature of Legal Guardian

TRANSFER OF CONSENT TO ANOTHER PARTY

I hereby authorize the following person(s) to consent to medical treatment for the above named child/children in my absence. Please include relationship and age or date of birth.

_____ _____

_____ _____

CONSENT FOR TEENAGE CHILD TO SEEK TREATMENT

I hereby authorize my teenage child/children to seek medical treatment in my absence.

Signed:_____
Signature of Legal Guardian

RELEASE OF INFORMATION

I hereby authorize the following person(s) to receive verbal or written communication related to the medical condition of the above listed child/children.

_____		_____	
Name	Relationship	Name	Relationship
_____		_____	
Name	Relationship	Name	Relationship

Signed:_____
Signature of Legal Guardian