**CONSENT TO TREAT**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT FOR TREATMENT**

I hereby authorize evaluation and treatment by the providers and staff associated with River Ridge Pediatrics. I understand and agree that the signatures and dates on this form will not expire without written notice or in the case that a minor becomes the age of 18, and that a photocopy of this form is considered valid as original.

**Printed Name of Parent or Guardian**

**Signature of Parent or Guardian Date**

**Printed Name of Parent or Guardian**

**Signature of Parent or Guardian Date**