



# Piedmont Internal Medicine

"PRIMARY CARE DOCTORS FOR ADULTS"

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## Consent for Treatment

I \_\_\_\_\_ verify that I am the parent and/or legal guardian for  
\_\_\_\_\_. I give my permission for the following people to provide  
their consent to obtain treatment for my child.

(List anyone who may bring your child to the doctor for treatment)

1. \_\_\_\_\_ Relationship \_\_\_\_\_
2. \_\_\_\_\_ Relationship \_\_\_\_\_
3. \_\_\_\_\_ Relationship \_\_\_\_\_
4. \_\_\_\_\_ Relationship \_\_\_\_\_
5. \_\_\_\_\_ Relationship \_\_\_\_\_

I understand that on arrival to the office, they may be asked for a drivers license, to verify their identity. In a serious or urgent situation, the office will make every effort to notify the parents and/or legal guardian. The number(s) where the parent/guardian can be reached are \_\_\_\_\_ and \_\_\_\_\_. I understand that in a true emergency the substitute caregiver will be directed to the emergency room. I have completed the above information. I have fully read and understand the above documentation.

Date: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Signature of Parent/Legal Guardian \_\_\_\_\_

Witness: \_\_\_\_\_