



Piedmont Internal Medicine

"PRIMARY CARE DOCTORS FOR ADULTS"

419 HOLIDAY COURT, SUITE 100
WARRENTON, VIRGINIA 20186

JOSEPH P. DAVID, M.D.
GERHARD K. KRASKE, M.D., M.P.H.
JAE Y. LEE, M.D.
DEMETRIUS S. MAOURY, M.D.
KEVIN C. MCCARTHY, M.D.
WILLIAM L. SIMPSON, M.D., MHSA

TEL: (540) 347-4200
FAX: (540) 341-7102

Consent for Treatment

I _____ verify that I am the parent and/or legal gaurdian for _____ . I give my permission for the folowing people to provide consent for treatment for our child/children.

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 attempt to notify the parents and/or legal gaurdian. The number(s) where I can be reached are _____ and _____. I understand that in an emergency the substitute caregiver will be directed to the emergency room. I have completed the above information. I have read and understand the above documentation.

Date: _____

Expiration Date: _____

Signature of Parent/Legal Guardian: _____

Witness: _____