Permission to Treat

Child/Children's Names _____

_____

Parent's name _____

Our phone number _____

Our address _____

_____

PERMISSION TO TREAT

We hereby give _____, (Relationship) _____,

permission to authorize medical treatment for the above named child/children to ABC Pediatrics, PLLC. This permission also includes any Xrays, lab tests or referrals that Dr. Barer or Dr. Ebalo may order on the above named child/children.

Authorized person's address: _____

_____

Phone _____ Cell phone _____

DOCTOR INFORMATION

ABC Pediatrics, PLLC

Evelyn Ebalo, M.D. / Lisa Barer, M.D.

1920 Black Lake Blvd S.W.

Olympia, WA 98512

Telephone: (360) 534-9222

Fax: (360) 534-9223

AUTHORIZED SIGNATURE - CHOOSE ONE

Mother's Name (Print): _____ Sign: _____

Father's Name (Print): _____ Sign: _____

Legal Guardian (Print): _____ Sign: _____

Date Signed: _____

This authorization is to remain in effect until further notice.