Pear Tree
MEDICAL ASSOCIATES

# Treatment Authorization for Minors and Dependents

This form authorizes treatment at Pear Tree Medical Associates. I, the Undersigned parent/guardian of

_____ (patient's full name), grant permission and

authorize medical care and treatment for my above mentioned child/ward to Pear Tree Medical

Associates physicians and staff. The healthcare provider(s) at Pear Tree Medical Associates or other

persons will act in reliance upon this authorization and medical information.

Please list the names of people who may have access to this dependent's medical records and also have

your permission to provide consent for treatment (for example: grandparents).

Name and Relationship: _____

Name and Relationship: _____

Parent/Guardian Printed Name: _____

Parent/Guardian Signature:_____Date:_____

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