1505 Northside Blvd, Suite 3600 Cumming, GA 30041

Tel: (770)888-8888 Fax: (770)888-4502

CONSENT TO TREAT

Permission is hereby given for patient _____,

Date of birth _____to receive any medical/surgical procedures, x-rays, drug or laboratory tests, medication or exam as may be deemed necessary by the physicians. In case of a minor, the consent below is given on his or her behalf.

Please Initial:

_____ I hereby authorize Cumming Pediatric Group, PC to obtain medical records from any other physician or medical facility necessary in the course of my child's treatment

_____ By signing this document, I acknowledge I have received and read the Cumming Pediatric Group, PC Notice of Privacy Practices and Individual Rights

_____ I hereby authorize messages to be left on a voice mail system or answering machine concerning my child

Parent / Legal Guardian *(Print Name)* **_____**

Parent / Legal Guardian *(Signature)* **_____ Date: _____**