ROBERT E. MILLER, M.D., F.A.A.P., P.A.

Pediatric and Adolescent Medicine

CONSENT FOR TREATMENT OF MINOR CHILDREN

Accompanied by an adult other than a parent or legal guardian

I, ____ , authorize
(Parent or legal guardian)

Dr. Robert Miller, M.D., FAAP, PA and staff to treat ____________________________
(child/ren)

for routine and emergency medical treatment when deemed necessary by qualified medical personnel when accompanied by:

____ ,
____ ,
____ .

This authorization is valid for:

☐ Today's visit only
☐ From______________________ (date) to ______________________ (date)
☐ Until revoked in writing by me

In addition, I authorize the adult accompanying this patient to complete the demographic form on my behalf and I will be bound legally to financial responsibility for this patient's medical treatment.

____
Printed name of parent/legal guardian

____
Signature of parent/legal guardian Date

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STATEMENT/0845-Consent 1/28/13