Patient Name ______________________ Date of Birth ______________

Authorization for Treatment

I hereby request and give my permission for the physicians' office of The Pediatric Specialists Medical Group to provide such medical examination and treatment as they deem best for the child's physical or mental welfare.

As parent ( ), or legal guardian ( ), I give full consent to Dr.'s Hasell, Pham, Hernandez, or Chris Pope ARNP, for medical examination and treatment for my child. I will notify the physicians' office of any change in the above information or permission.

The undersigned agrees to accept full responsibility for all charges due upon receipt of statement. I direct my insurer and third parties to pay directly to the physicians' office any insurance benefits due for services on behalf of the patient and I hereby assign to the physicians' office all my rights to receive payments from my insurer and third parties for services rendered in the physicians' office. I understand that I am responsible for any costs incurred in the collection of the patient's account in case of default, including reasonable attorney fees and/or court costs.

I agree that unless I give specific instructions otherwise, medical information regarding my child's diagnosis and treatment may be released to the natural mother, natural father, stepmother/stepfather, referring physicians, other physicians involved in the care of my child, and my insurance company/companies.

______________________ ______________

Signature of parent/legal guardian Date

I, ______________________, parent or legal guardian of the above patient, gives permission to ______________________, to seek medical treatment of my child.

(Print name of person authorized)

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Signature of notary

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Notary stamp