

## Azalea Pediatrics

### Consent To Treat Minor

I hereby give consent to Azalea Pediatrics to perform any radiology or lab testing, examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care as deemed advisable by a licensed physician, nurse practitioner or physician assistant, as well as any assistant on the staff of Azalea Pediatrics.

I understand that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required.

This consent is given to any and all such diagnoses, treatments and hospital care which a licensed physician at Azalea Pediatrics recommends.

This authorization will remain in effect until revoked in writing by the parent or legal guardian.

Signed: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please specify relationship to minor:

- Parent with legal custody
- Guardian with legal custody