PEDIATRIC ASSOCIATES OF FALL RIVER INC.

851 Middle Street, Suite 1100
Fall River, MA 02721

AUTHORIZATION FOR MEDICAL TREATMENT

I,_____ am the parent/legal guardian of
_____ DOB _____

I hereby give Pediatric Associates of Fall River, Inc. and all the physicians associated with their practice permission to extend the necessary medical treatment to my child.

I authorize _____ to accompany my child for his/her appointments in my absence. I understand that this form will stay in effect and it is my responsibility to inform Pediatric Associates otherwise.

I understand that it is my responsibility to be present for all scheduled physical examinations. This form is to be utilized in special circumstances for sick/recheck visits only.

_____ _____
Signature: Parent/Legal Guardian Date

_____ _____
Signature of Witness Date