Families First

support for families...health care for all

Permission to Treat Form

I, _____
Full Name (please print clearly) Relation to Patient

_____
Address Phone Number

authorize: _____
Full Name (please print clearly)

_____
Address City, State

_____
Phone Number

to bring _____
Patient's Full Name Date of Birth

to Families First for any medical or dental appointment. I give permission for the patient to be diagnosed, treated and prescribed medication during said appointment.

This authorization is valid for ONE YEAR from the date below and may be revoked at any time in writing prior to then.

_____
Patient/Legal guardian signature Date

_____
Print name of above signature