Pediatric Professional Association
10600 Quivira Rd., Ste 210
Overland Park, KS 66215
Fax 913-894-5522

Name of Child _____
DOB of Child _____
Name of Parent or Guardian _____
Chart Number _____

Consent to Treat Without Parent

I authorize the persons listed below to bring my child in to Pediatric Professional Association to receive medical attention without my appearance. I understand that medical information about my child may be provided to my caregiver. I may revoke this consent at any time with written notice. I understand this authorization will expire one year from date signed.

Name of Caregiver	Relationship to child	Date of Authorization
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____
Signature of Parent or Guardian

_____
Relationship to Patient

_____
Date

#2042 (2/05)