Statement of Permission to Treat

Date: _________________________

To Whom it May Concern:

I am the parent of:

_____________________________________
_____________________________________
_____________________________________
_____________________________________

I give permission to the following listed person(s) to obtain medical treatment for the above-referenced child(ren) with a provider of Five Oaks Medical Group or any facility which the provider deems necessary. This person(s) has my permission for medical decision making including but not limited to: administration of medication, diagnostic or therapeutic procedures, admission to the hospital, summary of visit, patient portal letter, etc.

Name:                    Relationship:
_____________________________________    ________________________________
_____________________________________    ________________________________
_____________________________________    ________________________________
_____________________________________    ________________________________

In an emergency, the parent(s) may be reached at: ________________________________

_____________________________________
Parent Signature