MIDDLETON PEDIATRICS
200 E. Marks St.
Orlando, FL 32803
407.284.6460

Authorization to Treat

Patient Name:______________________________________Date of Birth:_______________
Patient Name:______________________________________Date of Birth:_______________
Patient Name:______________________________________Date of Birth:_______________
Patient Name:______________________________________Date of Birth:_______________

I give permission for the following person(s) to accompany my child(ren) to office visits and sign for medical treatment on my behalf:

Name:______________________________________Relation to Child:_______________
Name:______________________________________ Relation to Child:_______________
Name:______________________________________ Relation to Child:_______________
Name:______________________________________ Relation to Child:_______________

From: ________________ Until: _______________ (not to exceed 1 year)

Parent/Legal Guardian Signature:____Date:_______________
Parent/Legal Guardian Name (please print):______________________________________
Parent/Legal Guardian Phone::____