MOORE PEDIATRICS & ASSOCIATES

AUTHORIZATION FOR TREATMENT

Patient(s)____

I, hereby grant permission to, authorize and direct the authorities of Moore Pediatrics & Associates to perform such medical and/or surgical procedures on my child as they deem in their judgement advisable or necessary for the treatment of care of (1) any conditions now recognized or contemplated, and (2) any conditions, not now recognized or contemplated, which are revealed or arise during the course of such treatment or care. I, acknowledge that no warranty or guarantee has been made as to the results that may be obtained from such treatment and care, that I understand the nature and purpose of the above authorized treatment, and that I have fully informed myself of contents and effects of the above Consent and Authorization, and do hereby freely give my consent thereto.

Signed______________________________**Date**_____________

Relationship to Patient___________________________________