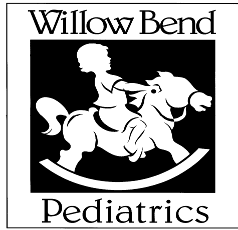


# Willow Bend Pediatrics

Michael J. Frank, M.D., F.A.A.P.
Kimberly F. Mehendale, M.D., F.A.A.P.
Susan J. Sickler, M.D., F.A.A.P.
Shobha Michaels, M.D., F.A.A.P

## Permission to Treat Form

Date: ___________________________

To Whom It May Concern:

I, _______________________________, guardian of ____________________________ give my
(Parent's Name) (Child's Name)

permission for ______________________________ to seek medical care and make medical decisions (Caretakers Name)

for my child as necessary on my behalf from ____/____/20___ to ____/____/20___.

________________________________ Parent's Signature ______________________ Date

________________________________ Witness Signature ______________________ Date

5940 Communications Parkway - Plano, Texas 75093 - Phone 972-403-9355 - Fax 972-403-1287