CHILDREN'S ORTHOPEDIC CENTER

SUSAN ATKINS,M.D.

1011 Hioaks Road, Suite D

Richmond, VA 23225-4040

Phone: (804) 272-0726

AUTHORIZATION TO TREAT/ SHARE MEDICAL INFORMATION

I give CHILDREN'S ORTHOPEDIC CENTER authorization to treat my child (who is a minor) and discuss medical information with the child and accompanying adult(s) in my absence.

DATE: _____ TO _____

NAME OF CHILD:_____

CHILD'S BIRTHDATE_____

PARENT/GUARDIAN SIGNATURE:_____

Signature affirms that parent/guardian is the legal representative for the above patient. If not specified, this release is valid for 12 months from date of signature below.

_____

NAME OF ADULT GIVEN PERMISSION TO AUTHORIZE CARE_____

RELATIONSHIP TO PATIENT _____