PERMISSION TO EVALUATE AND TREAT

I hereby give my permission to evaluate and treat my son/daughter

(name) ____

(date of birth) _______________________ without my being present at his/her appointment today or any future appointments with Dr. Michelle Higginson, Dr. Jennifer Gray, Alicia Beck, PA-C, or Brittany Giammalvo, PA-C.

____ ___________________

Print Name Relationship

____ ___________________

Signature Date