

# PEDIATRIC MEDICINE, PA

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Michael A. Ozer, M.D.  
Rebecca A. Rocha-Davis, M.D.  
Karen L. Gibbons, M.D.  
David M. Ross, Jr., M.D.  
Patricia Villarreal, RN, MS, CPNP

## CONSENT TO TREATMENT

I, \_\_\_\_\_ AM THE:  PARENT  
 LEGAL GAURDIAN  
 OTHER: \_\_\_\_\_  
(PLEASE SPECIFY)  
OF \_\_\_\_\_, I AUTHORIZE THE FOLLOWING:

NAME:	RELATIONSHIP
PERSON(S) _____	_____
PERSON(S) _____	_____

TO MAKE MEDICAL, AND SURGICAL DECISIONS  
(WHEN NECESSARY)

I HEREBY GIVE CONSENT TO:  DR. MICHAEL OZER  
 DR. REBECCA ROCHA-DAVIS  
 DR. KAREN GIBBONS  
 DR. DAVID ROSS  
 PATRICIA VILLARREAL, CPNP

AND THEIR ASSOCIATES TO EXAMINE AND ADMINISTER ANY  
NECESSARY MEDICAL/SURGICAL CARE (WHEN NECESSARY) FOR

\_\_\_\_\_  
(PATIENT'S NAME)

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE