

CONSENT TO TREATMENT

I, _____, hereby request healthcare services from Joan L.
(Parent or Legal Guardian – Print name)

Moreau, M.D. for my child, _____. I acknowledge and understand that no
guarantee or assurance has been made as to the outcome or results of those services.

With my signature, I am giving my permission for _____
(Name of Designee – Print name)

to accompany my child to appointments with Dr. Moreau and to make informed decisions on my child's
behalf.

Also, I attest that I am the legal guardian for _____.
(Name of Child – Print name)

Signed by Parent or Legal Guardian

Date