West Plano Pediatrics

6020 W. Parker Road, Suite 310
Plano , TX 75093
Phone 972-608-0774 Fax 972-608-0595
general@westplanopediatrics.com

Authorization for Treatment

l,	, hereby authorize and grant parental cons	
for	, DOB	, to receive
medical care and treatm	nent at West Plano Pediatrio	cs on the following date of
	_•	
I understand and agree directly to the patient ir	•	will be given and/or explained
Parent Signature		