201 NW 82nd Ave, Suite 104
Plantation, FL 33324
Phone: 954.472.2201
Fax: 954.472.2501

Authorization for Treatment

Today's Date: ______________________

Patient Name: _____________________________________ Patient D.O.B. _____________

I _____________________________________, parent/legal guardian of the above named patient, give parental consent to Dr. Robert Bass and his staff to render appropriate care to my child.

I UNDERSTAND THAT THESE RECORDS ARE CONFIDENTIAL AND CANNOT BE DISCLOSED WITHOUT WRITTEN AUTHORIZATION, EXCEPT OTHERWISE AS PROVIDED BY LAW. MY CONSENT MAY BE REVOKED AT ANY TIME. THIS AUTHORIZATION SHALL EXPIRE SIXTY (60) DAYS FROM THE DATE OF MY SIGNATURE.

Name (Print) ___________________________ Relationship to Patient: _________________

Signature: ____________________________________ Today's Date: _________________