



300 Dawson Commons Circle, Suite 320 · Dawsonville, GA 30534

Tel: (706) 216-2771 · Fax: (706) 216-2944

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### ***CONSENT TO TREAT***

Permission is hereby given for patient \_\_\_\_\_,  
Date of birth \_\_\_\_\_ to receive any medical / surgical procedures, x-rays, drug or  
laboratory tests, medication or exam as may be deemed necessary by the physicians. In  
case of a minor, the consent below is given on his or her behalf.

Please Initial:

\_\_\_\_\_ I hereby authorize Dawson Pediatrics, PC to obtain medical records from any other  
physician or medical facility necessary in the course of my child's treatment.

\_\_\_\_\_ By signing this document, I acknowledge I have received and read the Dawson  
Pediatrics, PC Notice of Privacy Practices and Individual Rights.

\_\_\_\_\_ I hereby authorize messages to be left on a voice mail system or answering machine  
concerning my child.

Parent / Legal Guardian: \_\_\_\_\_  
*Print Name*

Parent / Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_  
*Signature*