Robert M Olivieri MD
Lauren Healy MD
Amy Chang MD
722 Yorklyn Road
Hockessin DE 19707
302.235.1188

John W Murphy MD
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210 Christiana Medical Center
Newark DE 19702
302.368.2501

Treatment Authorization

Patient Name________________________________**Birthdate**______________________________

I, ____(Parent/Guardian) hereby give my full permission and authorization to First State Pediatrics to see and treat my child medically. This permission/authorization shall be and remain in effect until cancelled in writing.

As the parent/legal guardian of ________________________________(child), I hereby authorize the

following person(s)____

____

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to accompany my child named above to office visits at First State Pediatrics, and to consent to the examination and/or treatment of my child during these office visits.

This authorization is effective until revoked by me in writing, and I reserve the right to revoke this authorization at any time.

_____________________________________ _____________________________________

Parent/Guardian Date

New Policy Regarding Missed Appointments

I am aware as of January 1, 2012, there will be a **$25** fee for missed appointments. Appointments may be cancelled with 24 hours advance notice.

_____________________________________ _____________________________________

Parent/Guardian Date

Revised 3/17/2014