ANGIER PEDIATRICS AND ADULT MEDICAL CENTER, PLLC

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OFFICE: 919-577-0481
FAX: 919-577-0512

CONSENT FORM FOR PATIENT CARE

Printed Name of Patient: _____ **Date of Birth:** _____

I hereby authorize the following individuals permission to bring in my _____for any appointments scheduled at the above-named practice.

_____	_____
PRINTED NAME	**RELATIONSHIP**
_____	_____
PRINTED NAME	**RELATIONSHIP**
_____	_____
PRINTED NAME	**RELATIONSHIP**
_____	_____
PRINTED NAME	**RELATIONSHIP**

_____ _____
Signature of Patient or Legal Representative **Date**

_____ _____
Representatives Relationship To Patient and Phone Number **Date**