

AUTHORIZATION TO TREAT

I, _____, mother/father/legal guardian of
(Parent/guardian name)

_____, authorize
(Patient name)

_____, _____, to bring
(Name of person bringing patient) (Relationship of person to patient)

_____ for medical care. I further authorize the staff at
(Patient's first name)

Bleeding & Clotting Disorders Institute and Michael Tarantino, M.D. S.C. to treat

_____, without my presence, for all medical care.
(Patient's name)

This is to include office visits, infusions, labs, infusion training and any other care, treatment or training as deemed appropriate by the staff of the providers listed above.

This authorization is valid for one year, through _____.
(One year from date of visit)

Signature of Patient/Legal Guardian

Date