



Luv-N-Care Pediatrics

AMBREEN ASLAM, M.D., FAAP

Authorization for Medical Treatment

Name of Patient

Date of Birth

I, _____, the parent / guardian of above patient at Luv-N-Care Pediatrics, hereby give permission to **Dr. Ambreen Aslam**, as the child's physician, and such associates, **Medical / Technical Assistants**, and other health care providers as deemed necessary to provide medical care. Furthermore, I also authorize the following persons to bring the child to his / her appointments as needed.

Name

Relationship to Patient

1. _____

2. _____

3. _____

Signature of Parent / Guardian

Date