TO: NEWARK PEDIATRICS, P.A.
314 East Main Street
101 Kelway Plaza
Newark, DE 19711

J. Bartley Stewart, Jr.,M.D.
Sangita P. Modi, M.D.
Jason D. Walker, M.D.

RE:____
(Patient's Name)

MEDICAL TREATMENT AUTHORIZATION AND CONSENT FORM

I,__________________________________, __________________________
Parent or Guardian | Relationship to Patient

designate and authorize the following persons to arrange for examination and treatment of my above named minor child by the physicians of Newark Pediatrics, P.A.

____________________________ ____________________________

____________________________ ____________________________

____________________________ ____________________________

This authorization will remain in effect for as long as my child is a patient in this practice unless, otherwise, notified in writing.

____________________________ ____________________________
Signature Parent or Guardian | Printed Name Parent or Guardian

Home and Work Phone Numbers: H______________W__________________

__________________________________ __________________
Witness | Date