Willy Pezzia, M.D., P.A. & Associates

Willy Pezzia, M.D.
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Authorization for Medical Evaluation on Behalf of a Minor

Name of patient: ______________________ Date Of Birth: ________________

I give permission for **Willy Pezzia, M.D. & Associates** to provide medical evaluation services to the minor named above. This consent begins on the date below and remains in effect one year from the date signed, unless revoked in writing.

____
Printed name of person giving consent

____
Signature of person giving consent

____
Relationship to Minor

____
Date Signed