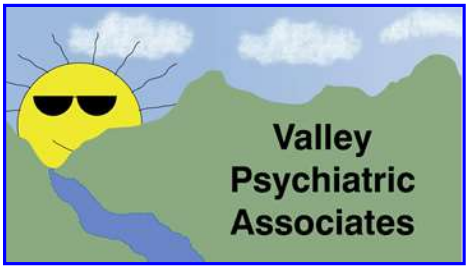

Child, Adolescent, and Family Psychiatry

Albert L. Sprinkle III, M.D.

190 Lime Quarry Rd, Suite 115, Madison, AL 35758

Phone : 256-270-9483 **FAX :** 256-325-0340

Date: _____

I, _____, the _____ of _____, am authorizing
Please print your full name *relation to patient* *full name of patient*

_____ to be able to consent for medical treatment for _____ on my behalf.
Full name of non-parent bringing child *full name of patient*

_____
Signature of Parent, or Guardian

_____
Witness