Chad P. Nevola M.D., Inc.

120 Dudley Street, Suite 105
Providence, Rhode Island 02905
401-273-9555

AUTHORIZATION FOR UNACCOMPANIED CHILD CARE

I, ______________________________________, hereby authorize Chad P. Nevola, M.D., Inc.
Parent/Legal Guardian

to examine and treat my minor child, ____,
Patient Name

birthdate, _______________, when he/she is unaccompanied. I understand that I may revoke

this consent at any time.

Signature of Parent/Legal Guardian: ____________________________ Date: ____________