



Chad P. Nevola M.D., Inc.

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

**CONSENT FOR CARETAKER - AUTHORIZATION FOR 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 accompanied by,

\_\_\_\_\_, relationship to patient, \_\_\_\_\_.  
Caretaker

I understand that I may revoke this consent at any time.

Signature of Parent/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_