

Tilley Family Medicine

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J. Brad Tilley, M.D.
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Amber Tilley, APRN

Date: _____

Patient's Name: _____

Date of Birth: _____

I, _____, give permission for Tilley Family Medicine to treat my
(Parent/Guardian)

child, _____, in my absence.
(Name of Patient)

Parent/Guardian – please print

Parent/Guardian – please sign/date

Parent/Guardian contact ph#