Pediatric & Adolescent Care

I AUTHORIZE THE FOLLOWING PERSONS ACCESS TO:

Please initial below each name what information you would like that individual to be able to access

(I/We) hereby give authorization to the physicians and staff of Pediatric and Adolescent Care, LLP, to treat my child(ren) with reasonable and proper medical care by today's standards if I cannot be reached for verbal authorization.

Patient Name_____**DOB:**_____

NAME: _____ **RELATIONSHIP:** _____

Billing Info_____ **Authorize Vaccines**_____ **Patient Info**_____

(making appointments, requesting prescriptions)

NAME: _____**RELATIONSHIP:** _____

Billing Info_____ **Authorize Vaccines**_____ **Patient Info**_____

(making appointments, requesting prescriptions)

NAME: _____ **RELATIONSHIP:**_____

Billing Info_____ **Authorize Vaccines**_____ **Patient Info**_____

(making appointments, requesting prescriptions)

NAME: _____ **RELATIONSHIP:**_____

Billing Info_____ **Authorize Vaccines**_____ **Patient Info**_____

(making appointments, requesting prescriptions)

NAME: _____ **RELATIONSHIP:**_____

Billing Info_____ **Authorize Vaccines**_____ **Patient Info**_____

(making appointments, requesting prescriptions)

Authorization above will remain in effect until rescinded in writing; or until _____.

Date Specified

Signature for authorization: _____**DATE:**_____

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