AUTHORIZATION TO OBTAIN TREATMENT

Account # _____

Parent/Guardian

In the event you are not able to bring your child in to the office for treatment, we must have an authorization on file stating who is authorized to obtain treatment for your child. Please fill out the following, read and sign the authorization.

Patient Name _____ Date of Birth _____

Parent names _____

Legal guardian/custodian/representative _____

I authorize the following person (s) to obtain treatment (including immunizations) for the patient listed above from PROMISE PEDIATRICS.

NAME	RELATIONSHIP TO PATIENT
_____	_____
_____	_____
_____	_____
_____	_____

This authorization shall remain in effect indefinitely, unless withdrawn by my written request.

_____ _____

Signature Relationship to patient

WITHDRAWAL OF AUTHORIZATION

I request the above authorization be withdrawn effective _____

_____ _____

Signature Date