Clermont Pediatrics, P.A.

1755 E. Highway 50, Suite A
Clermont, FL 34711
Tel.: (352) 394-7125
Fax: (352) 394-2584

AUTHORIZATION FOR MEDICAL CARE

I (WE) _____ authorize
PRINT NAME OF LEGAL GUARDIAN(S)

Clermont Pediatrics, P.A. and it's personnel to deliver medical services to

my child _____ .
PRINT CHILD'S NAME AND DATE OF BIRTH

I (WE) authorize the following people to bring my child in for treatment: (This form must be filled out in order for anyone other than parents listed on patient information form to bring in your child.)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

x _____ _____
SIGNATURE OF LEGAL GUARDIAN DATE

Relationship to patient: _____

_____ _____
WITNESS (PRINT/SIGN) DATE