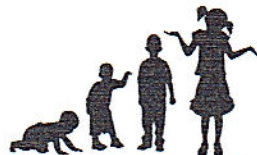


W. David Carr, M.D.
Kellie Cordovano, A.R.N.P.
Vanetta Anderson, A.R.N.P.



PEDIATRICS PLUS

"We Love Our Kids"

I, _____ (PARENT/LEGAL GUARDIAN) OF
CHILD/CHILDREN LISTED BELOW GIVE PERMISSION FOR
_____ WITH DRIVER'S LICENSE # _____
TO BRING MY CHILD/CHILDREN TO PEDIATRICS PLUS. HE OR SHE IS
AUTHORIZED TO ACT IN MY BEHALF IN DECIDING, ALLOWING AND
SIGNING FOR MEDICAL TREATMENT THAT MY CHILD/CHILDREN NEED
DURING MY ABSENCE.

CHILD/CHILDREN'S NAME(S)	DATE OF BIRTH
1. _____	_____
2. _____	_____
3. _____	_____

CURRENT INSURANCE INFORMATION AND REQUIRED CO-PAYMENT OR FULL PAYMENT FOR SERVICES RENDERED AT THE TIME OF VISIT WILL BE PROVIDED BY THE AUTHORIZED PERSON LISTED ABOVE. IF PEDIATRICS PLUS IS UNABLE TO OBTAIN PAYMENT FROM OUR INSURANCE COMPANY, I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR FEES ASSOCIATED WITH SERVICES RENDERED FOR THE CARE AND TREATMENT OF MY CHILD/CHILDREN.

PARENT/LEGAL GUARDIAN'S SIGNATURE

DATE

THIS AUTHORIZATION IS ONLY VALID FOR ONE YEAR FROM THE DATE OF NOTARIZATION

NOTARIZED BY:

PRINT NAME _____
SIGNATURE _____
DATE _____

NOTARY STAMP