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

PEDIATRICSPLUS
"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

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