GREENWOOD PEDIATRICS MEDICAL CARE

AUTHORIZATION FORM

Please review the following Authorization for Treatment. Complete the information if you would like to grant prior permission for medical treatment for your child/ren in the event of your absence.

Name of Child/ren	Date of Birth
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I hereby authorize **(name and contact number of the person(s) who will be caring for the child)** _____phone #:_____to sign for medical treatment (including preventative care, immunizations, urgent and emergent care) by Greenwood Pediatrics and its personnel for the above named child/ren.

Signature:_____ Date:_____

Print name:_____ Relationship to child:_____

This authorization is in effect for the following dates:

From:_____ Until_____

Please contact me regarding health care for my child/ren at the phone numbers found in our most recent patient information form. I agree to keep Greenwood Pediatrics informed of changes in our phone numbers, contact info and any custodial changes related to my child/ren listed above.