nataloni
Pediatrics P.C.

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PERMISSION TO ACCOMPANY CHILD

I(We), _____

authorize Nataloni Pediatrics, P.C. and its personnel to deliver medical services to my(our) child(ren):

Child/Patient Name _____

Date of Birth _____

Child/Patient Name _____

Date of Birth _____

Child/Patient Name _____

Date of Birth _____

I(We), hereby authorize _____

to accompany my(our) child(ren) to the office of Nataloni Pediatrics, P.C.. I(We) authorize Nataloni Pediatrics, P.C. to disclose any personal health information relating to said child(ren) pertinent to the accompanied visit(s).

Parent/Legal Guardian Name _____

Patient/Legal Guardian Signature:_____

Date: _____

Witness Signature:_____

Date: _____

Date of Authorization Expiration: _____