
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: