APC PEDIATRICS

5255 Office Park Blvd Suite 110
Bradenton, Fl 34203
1862 Rye Road Suite 101
Bradenton Fl 34212
941-755-7000 Fax 941-755-7088

Parents:

This form is to authorize (Mr./Mrs) ________________________________ to bring my
(Other than mother or father)

Child ________________________ for medical treatment at this office.
(Child's name)

Relationship to Patient, please choose one (Grandfather/Grandmother/Aunt/Uncle/Other)

If Other, please specify relationship to patient: ________________.

Name of the parent ____________________________________ Date signed__________

If at anytime the person you have listed above is not allowed to bring your child, it is your responsibility to inform us with a new letter stating or signing a new form that you are withdrawing your permission.

Witness ___________________

Rev. 08/2014