Westerville Pediatric Specialists, Inc.
575 Westar Crossing, Suite 101
Westerville OH 43082
Tel: 614/508-2223
Fax: 614/508-2233

AUTHORIZATION TO SEEK MEDICAL CARE

Note: It is <u>NOT</u> necessary to list parents/legal guardians on this form.

Patient(s) name(s): _____

_____

The individuals named below and their relationship to the patient(s) are authorized to schedule appointments and seek care **<u>for illness or injury</u>** for the above-named patient(s) with the physicians and nurse practitioners of Westerville Pediatric Specialists, Inc. *Please be advised the individuals named below are people who will have access and knowledge of private health information.*

1) _____
Relationship

2) _____
Relationship

3) _____
Relationship

4) _____
Relationship

Please note: We understand that grandparents, babysitters, or others may render care for your children. However, if the Westerville Pediatric Specialists, Inc. visit is for a routine well-care visit, it is our policy not to perform such services <u>unless a parent or legal guardian is present</u>. **Additionally, immunizations must be authorized by the parent or legal guardian by federal law.**

---------<u>DO NOT COMPLETE BELOW PORTION UNTIL IN THE PRESENCE OF A NOTARY</u>---------

I _____, parent/legal guardian of the above-named patient(s) give
Parent/Legal Guardian (printed)

permission for the above-named authorized individuals to seek medical care in my absence.

_____ _____
Parent/Legal Guardian Signature ***Date***

Notary: _____ **Witness:** _____

County: _____ **State:** _____ **Expires:** _____