



Lehigh Valley Pediatric Associates, Inc.

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### AUTHORIZATION

I, \_\_\_\_\_, the parent and/or legal guardian of,  
\_\_\_\_\_  
\_\_\_\_\_ hereby authorize,  
\_\_\_\_\_ to accompany my above named  
child(ren) to office visits at Lehigh Valley Pediatric Associates, Inc. and to consent to the examination and/  
or treatment of my child(ren) during office visits.

**This authorization:**

\_\_\_\_\_ is effective on \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_ is effective from \_\_\_\_\_, 20\_\_\_\_ to \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_ is effective until revoked by me in writing.

**I reserve the right to revoke this authorization at any time by writing to the above named pediatric group.**

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Parent/Guardian: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Witness: \_\_\_\_\_

