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 Wirness:_____

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