



# Clermont Pediatrics, P.A.

1755 E. Highway 50, Suite A  
Clermont, FL 34711  
Tel.: (352) 394-7125  
Fax: (352) 394-2584

## AUTHORIZATION FOR MEDICAL CARE

I (WE) \_\_\_\_\_ authorize  
PRINT NAME OF LEGAL GUARDIAN(S)

Clermont Pediatrics, P.A. and it's personnel to deliver medical services to  
my child \_\_\_\_\_  
PRINT CHILD'S NAME AND DATE OF BIRTH

I (WE) authorize the following people to bring my child in for treatment:  
(This form must be filled out in order for anyone other than parents listed  
on patient information form to bring in your child.)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

*x* \_\_\_\_\_  
SIGNATURE OF LEGAL GUARDIAN DATE

Relationship to patient: \_\_\_\_\_

\_\_\_\_\_  
WITNESS (PRINT/SIGN) DATE