Center For Pediatric Medicine *Our Family Caring For Yours*

Designation of Authorized Representative

TO: Center for Pediatric Medicine, PC

FROM: _____
(Parent/Legal Guardian's Name)

Please be advised that _____ is an authorized representative for my child/children (list childrens' names and dates of birth):

_____

_____

_____.

This authorization will expire on _____.

_____ _____
(Signature of Parent/Guardian) (Today's Date)

_____ _____
(Print Name of Parent/Guardian) (Relationship to Patient)