Pediatric Practices of Northeastern Pennsylvania

1837 Fair Ave.	27B Woodlands Drive	510 Routes 6 & 209	62 Industrial Park Road
Honesdale, PA 18431	Waymart, PA 18472	Milford, PA 18337	Lake Ariel, PA 18436
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Fax: 570-253-6678	570-488-9553	570-296-5480	570-689-4803

MEDICAL TREATMENT AUTHORIZATION

I, _____, the parent and/or legal guardian of

_____ _____, hereby authorize
(Patient Name) (Date of Birth)

_____ to
(Name/Address of person accompanying child)

accompany my above-named child to office visits with Pediatric Practices of Northeastern PA and to consent to the examination, diagnostic testing, immunization, and/or treatment of my child during office visits.

This authorization:

_____ is effective only on _____, 20__ __.

_____ is effective only on _____, 20__ __ to _____, 20__ __,

_____ is effective until revoked by me in writing.

I reserve the right to revoke this authorization at any time in writing to Pediatric Practices of Northeastern PA.

_____ _____
SIGNATURE (Parent/Guardian) DATE

_____ _____
WITNESS SIGNATURE DATE