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HIPAA AUTHORIZATION

DATE _____

My child(ren)'s name: _____ DOB: _____
_____ DOB: _____
_____ DOB: _____
_____ DOB: _____
_____ DOB: _____

I hereby give permission to share information and/or bring my child in to Mendon Pediatrics to render medical services to:

_____ relationship_____
_____ relationship _____
_____ relationship _____

**If there are older siblings that might bring younger siblings in to be seen, please write down who you are authorizing to bring your child(ren) in.

_____ relationship _____
_____ relationship _____

PLEASE REMEMBER: YOU MUST SEND A NOTE WITH THE CHILD BEING SEEN, IN YOUR ABSENCE, GIVING PERMISSION FOR SHOTS/BLOODWORK TO BE DONE.

Also, please provide phone numbers for parents, in case we need to reach you while your child is here!

Mom _____ Dad_____

Signature of Parent_____