Brighton Pediatrics

PARENT AUTHORIZATION FORM

Date _____

Name of Child/ren	Date of Birth
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I, _____

(Printed name and relationship to patient)

Hereby grant permission for _____

(printed name and relationship to patient)

To seek medical treatment for my above-named child/ children at Brighton Pediatrics. This authorization includes, preventive care, immunizations, urgent and emergent care by Brighton Pediatrics and its personnel.

Signature _____

This authorization is in effect for the following dates:

From _____ Until _____