Pediatrics Associates

450 Veterans Memorial Parkway, Building 10, E Prov., RI 02914 (401) 438-6888

Parental Authorization for a Minor Child

This authorization is for patients under 18 years of age.

We must have permission from a child's parent or guardian before providing medical services or advice. If you feel there may be an occasion where your child will be brought in by someone other than either parent or guardian or someone may call for advice on your child's behalf, please fill out the following information to be included in your child's records.

Patient's Name: _____ Date of Birth: _____

The following person(s) have my permission to authorize medical care/advice for my child and sign any necessary waivers on my behalf:

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Signature of
Parent or
Legal Guardian: _____ Date: _____

This authorization will remain in effect until changed by Parent or Legal Guardian above.