AUTHORIZATION TO OBTAIN TREATMENT

Parent/Guardian

In the event you are not able to bring your child into the office for treatment, we must have an authorization on file stating who is authorized to obtain treatment for your child. Please fill out the following, read and sign the authorization.

Patient Name _____ DOB: _____

Parent Names: _____

Legal guardian/ custodian/ representative _____

I authorization the following person(s) to obtain treatment (including immunizations) for the patient listed above from **Ringgold Pediatric Clinic, P.C.**

Name	Relationship to Patient
_____	_____
_____	_____
_____	_____
_____	_____

This authorization shall remain in effect indefinitely, unless withdrawn by my written request.

_____ _____

Signature Relationship to Patient/ Date

AUTHORIZATION TO LEAVE PHONE MESSAGES

DO _____ **DO NOT** _____

I authorize Ringgold Pediatric Clinic to leave a phone message to any number I listed on the patient information form, to remind me of my appointment and share health information.

_____ _____

Signature Date