West Erie Medical Group

1600 Peninsula Drive, Suite 9 • Erie, PA 16505 • (814) 877-7035 • Fax: (814) 877-6276

AUTHORIZATION

I, _____, the parent/legal guardian of

_____, date of birth_____

Herby authorize_____,Relationship_____

To accompany my above name child to office visits with West Erie Medical Group, or covering physician in his/her absence. I give my consent to the examination and/or treatment of my child during the office visit(s).

This authorization: (Please check one that applies)

_____ is effective only on this date_____

_____is effective from _____ to _____

_____ is effective until revoked by me in writing.

I reserve the right to revoke this authorization at any time by writing to the above named Physician or facility.

Date _____ Signature _____

Signature of Witness_____

Hamot