# CONYERS PEDIATRICS

To Whom It May Concern:

I am the legal parent and/or guardian of _____, date of birth _____, a patient under the care of Conyers Pediatrics, PC.

In the event I an unable to accompany _____ to Conyers Pediatrics, I authorize the following person(s) to serve as my representative(s) and bring my child to the office for treatment. I authorize Conyers Pediatrics,, its physicians and staff, to provide medical information to the following person(s) pertinent to my child's immediate care to as if I were personally present. I understand that each person designated may be required to provide a copy of a photo ID. **This authorization is valid for one year from the date of signature and should be updated yearly.**

| | |
|---|---|
| _____ Name | _____ Relationship |
| _____ Name | _____ Relationship |
| _____ Name | _____ Relationship |
| _____ Parent or Guardian | _____ Date |
| _____ Witness | _____ Date |

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The parent or guardian of _____ is not present. By signing below, we verify that this form has been read to _____, the parent or guardian, and verbal permission has been granted over the telephone for treatment as determined by the physician, including but not limited to laboratory tests, xrays, injections, immunizations, etc.

This the ___ day of _____.

| | |
|---|---|
| _____ Employee Name | _____ Title |
| _____ Employee Name | _____ Title |

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