PERMISSION TO AUTHORIZE CARE

To Whom It May Concern:

I, the undersigned parent, or legal guardian, does hereby give the following individual(s):

Name:	**Relationship to Child/Patient:**
______________________________	_______________________________
______________________________	_______________________________
______________________________	_______________________________
______________________________	_______________________________

permission to authorize the Health & Wellness Center (Doctor/Nurse/PA/ARNP, LBHP, etc.) to provide routine (normal) or emergency care as they deem necessary in the best interest and health of my child/patient:

Child's/Patient's Name:____

DOB:_____/______/______ Child/Patient's Social Security #:_____-_____-_____

This authorization shall remain in effect until revoked by me.

____ ______________________

Signature of Parent/Legal Guardian Date

____ ______________________

Verification Signature Date