Kiddie West Pediatric Center
4766 West Broad St.
Columbus, OH 43228

AUTHORIZATION TO SEEK MEDICAL CARE

THIS FORM MUST BE NOTARIZED

Patient(s) name(s): ____________________________ ____________________________
____________________________ ____________________________
____________________________ ____________________________

The following individuals named below and their relationship to the patient(s) are authorized to schedule appointments and seek care for illness or injury for the above named patient(s) with the physicians and nurse practitioners of Kiddie West Pediatric Center. Please be advised the individuals named below are people who will have access and knowledge of private health.

1.)____
Relationship

2.)____
Relationship

3.)____
Relationship

4.)____
Relationship

I____, parent/legal guardian of the above named patient(s) give permission for the above named authorized individuals to seek medical care in my absence.

____
Printed Name Signature Date

State of Ohio)
)ss
County of ______________________________)

Subscribed, sworn to, and acknowledged before me this ____ day of ___________, ______________________

____
Notary Public