SUN CITY PEDIATRICS, PA
11160 La Quinta Place
El Paso, Texas 79936
(915) 591-1494
Fax: (915) 598-0610

AUTHORIZATION BY PARENT OR LEGAL GUARDIAN FOR ANOTHER PERSON TO BRING MINOR TO SUN CITY PEDIATRICS, PA

I, _____
Name of Parent or Legal Guardian

do hereby state that I am the ☐ Father, ☐ Mother ☐Legal Guardian of:

_____, a minor, born
Patient's Name

on _____ who resides with me at
Patient's Date of Birth

_____
Current Address

I hereby provide permission for the following person(s), who are adults over 18 years of age, to bring my child to the office:

Name(s):	Relationship to Child
_____	_____
_____	_____

I understand that when the person(s) identified above takes my child to Sun City Pediatrics, PA for a medical problem, the part of my child's protected health information that the medical provider(s) determines relevant to the office visit must be disclosed to this person.

I understand that when the person(s) identified above takes my child for a well visit or for treatment of a medical problem, that, this person may need to provide consent for my child to receive medical services the healthcare provide(s) determines necessary for the care and treatment of my child. I hereby authorize the person(s) listed above to provide consent for the provision of the following medical services to my child by the medical providers at Sun City Pediatrics, PA. (Please, check which services you are authorizing the above named person(s))

__ Evaluation __ Treatment __ Administration of Vaccines

_____ _____
Name of Parent or Legal Guardian Signature

_____
Date Signed

This authorization shall be valid for each visit that the person(s) identified above brings your child to Sun City Pediatrics, PA office unless you provide written notice to Sun City Pediatrics, PA that you are revoking authorization.
(Esta autorización sera válida por cada visita en que la persona(s) identificada(s) en esta forma traiga al paciente a nuestra oficina a menos que usted provéa una forma oficial por escrito revocando esta autorización).