

Cary/Apex/Fuquay-Varina Pediatric Centers



Authorization to Obtain Medical Care Without Guardian

Child's Name: _____ Child's Date of Birth: _____

I, being the parent or guardian of the above named child, do hereby request and authorize any physician or nurse practitioner of the Cary, Apex or Fuquay-Varina Pediatric Centers and his/her staff to perform necessary services for my child (who is at least 16 years of age), which are deemed advisable by the provider, without myself or a guardian present at the actual appointment.

I request this authorization remain in effect until _____(date), or _____indefinitely.

I understand that I may revoke this authorization at any time, by submitting a written request.

Signature of Parent or Guardian

Relationship to child

Date and Time

Witness

Date and Time