Cary/Apex/Fuquay-Varina Pediatric Centers

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 which are deemed advisable by the provider, whether or not I am present at the actual appointment.

I authorize the following individuals to obtain medical care for this child, in my absence:

_____	_____
Name	Relationship to Child
_____	_____
Name	Relationship to Child
_____	_____
Name	Relationship to Child
_____	_____
Name	Relationship to Child

I further authorize the release of protected health information, to the individuals named above, regarding the child whose name appears atop this document. The following are any exceptions/restrictions to this authorization:

_____

_____

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 Printed name of Parent or Guardian

Date _____

I acknowledge that I have received Notice of Privacy Practices _____

Initials