Penfield Pediatrics, LLC 21 Willow Pond Way, Suite 200 Penfield, NY 14526

I, _____,(print name), relationship to patient(s),_____, give my permission to _____,(print name) relationship to patient(s),_____ to seek medical care, routine or emergency, including administration of immunizations, determined by a physician to be necessary for the welfare of my child/children listed below:

Name: _____, DOB_____

Name:_____, DOB_____

Name:_____, DOB_____

Name:_____, DOB_____

Name:_____, DOB_____

I understand this authorization can be revoked at any time by written request and is valid for **one year from signature date.**

Parent/Guardian Name_____

Parent/Guardian Signature_____

Date_____