

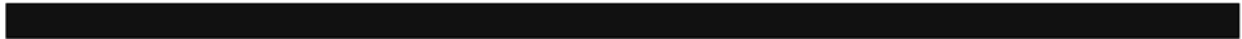


Name of Patient(s): _____

This is to certify that I, _____, have received a copy of the

Notice of Privacy Practice Act.

Signature: _____ Date: _____



I, _____ (Print your name) authorize the following

_____ (Person's name & relationship to client) and

_____ (Person's name & relationship to client)

to bring my child _____ (Print name of child),

to Dr, Kenawy at Emerald Coast Pediatrics for medical care and treatment in my absence.

SIGNED: _____ Date: _____

Relationship to Patient: _____

Witnessed By:

Print name: _____

SIGNED: _____ Date: _____