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:_____