Name of patient: _____ DOB: _____

Beachside Pediatric Associates, P.A.

Dr. Lalitha Vadlamani-Simmers

saving lives - making a difference

# Authorization for Treatment of Minor

By signing this form, I, _____ , am giving the following individual(s) permission to bring my child, _____ , for medical treatment and receive medical information from Beachside Pediatric Associates, PA regarding the same.

_____ _____
Name Relation to patient

_____ _____
Name Relation to patient

_____ _____
Name Relation to patient

This Authorization will remain in effect for one year from the date of this form being signed by minor's parent/guardian unless Beachside Pediatric Associates, PA is notified in writing that this authorization should be terminated.

_____ _____ _____
Name of parent/ legal guardian Signature of parent/legal guardian Date

_____ _____ _____
Beachside Pediatric Associates Rep. Signature of Representative Date