



176 N. Village Ave., Suite 1D  
Rockville Centre, NY 11570  
(516) 766-4094 (p)  
(516) 766-4092 (f)  
www.abcpeds.com  
[reception@abcpeds.com](mailto:reception@abcpeds.com)

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I (We) \_\_\_\_\_ authorize ABC Pediatrics, P.C. and its personnel to  
*PRINT NAME OF LEGAL GUARDIAN(S)*  
deliver medical services to my child, \_\_\_\_\_.  
*CHILD'S NAME AND DATE OF BIRTH*

I (We) authorize the following people to bring my child in for treatment:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
*(PLEASE PRINT)*

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
*(PLEASE PRINT)*

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
*(PLEASE PRINT)*

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
*(PLEASE PRINT)*

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*SIGNATURE OF LEGAL GUARDIAN*

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*DATE*

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*RELATIONSHIP TO PATIENT*