Westerville Pediatric Specialists, Inc.
575 Westar Crossing, Suite 101
Westerville OH 43082
614/508-2223

Sunbury Mills Pediatrics
450 South Miller Drive, Suite 100
Sunbury OH 43074
740/965-6369

AUTHORIZATION TO SEEK MEDICAL CARE

Patient(s) name(s): _____

_____

_____

The following individuals named below and their relationship to the patient(s) are authorized to schedule appointments and seek care for illness or injury for the above named patient(s) with the physicians and nurse practitioners of Westerville Pediatric Specialists, Inc. Please be advised the individuals named below are people who will have access and knowledge of private health information:

1) _____
Relationship

2) _____
Relationship

3) _____
Relationship

4) _____
Relationship

Please note: We understand that grandparents, baby sitters, or otherwise might render care for your children. However, if the visit with Westerville Pediatric Specialists, Inc. is for a well child routine visit, it is the policy of Westerville Pediatric Specialists, Inc. not to perform such services unless a parent, or legal guardian is present. **Additionally, immunizations must be authorized by the parent or legal guardian by federal law.**

I _____, parent/legal guardian of the above named patient(s) give permission for the above named authorized individuals to seek medical care in my absence.

_____
Printed Name Signature Date

Notary: _____ Witness: _____

County: _____ State: _____ Expires: _____

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Authorization for Step-parent To Seek Medical Care

Patient(s) name(s): _____

_____

_____

The following **step-parent(s)** named below is authorized to schedule appointments and seek care for well child routine visits including immunizations, illness or injury for the above named patient(s) with the physicians and nurse practitioners of Westerville Pediatric Specialists, Inc. Please be advised the individuals named below are people who will have access and knowledge of private health information:

_____

I _____, parent/legal guardian of the above named patient(s) give permission for the above named authorized individuals to seek medical care in my absence.

_____

Printed Name Signature Date

Notary: _____ Witness: _____

County: _____ State: _____ Expires: _____

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Authorization for Co-Custodial Parent To Seek Medical Care

Patient(s) name(s): _____

_____

_____

The following **co-custodial parent(s)** named below is authorized to schedule appointments and seek care for well child routine visits including immunizations, illness or injury for the above named patient(s) with the physicians and nurse practitioners of Westerville Pediatric Specialists, Inc. Please be advised the individuals named below are people who will have access and knowledge of private health information:

_____

I _____, parent/legal guardian of the above named patient(s) give permission for the above named authorized individuals to seek medical care in my absence.

_____

Printed Name Signature Date

Notary: _____ Witness: _____

County: _____ State: _____ Expires: _____