AUTHORIZATION FOR CHILD TO RECEIVE CARE

I hereby authorize Litchfield County Pediatrics to examine and treat my minor child:

Name: _____
DOB: _____

when he/she is accompanied by:

Responsible adult: _____
Relationship to patient: _____

I understand that I may revoke this consent at any time.

_____ _____
(Parent/Legal Guardian) (Date)

----------**OR**----------

I hereby authorize Litchfield County Pediatrics to examine and treat my minor child:

Name: _____
DOB: _____

when he/she is unaccompanied by an adult. I understand I may revoke this consent at any time.

_____ _____
(Parent/Legal Guardian) (Date)

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