



556 Sandhurst Drive
Fayetteville, NC 28304

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Fax (910) 483-9470

www.legacypeds.com

Authorization by Parent/Legal Guardian

Patient's Full Name: _____

Patient's Date of Birth: _____

The following individuals have my permission to bring my child (as named above) to Legacy Pediatrics as well as participate in full consultation and authorized care with the doctor. They are also authorized to have access to my child's protected health information on a routine basis.

1. _____

Relationship to child: _____

2. _____

Relationship to child: _____

3. _____

Relationship to child: _____

4. _____

Relationship to child: _____

5. _____

Relationship to child: _____

Parent/Legal Guardian Signature

Date