556 Sandhurst Drive
Fayetteville, NC 28304

(910) 483-2646
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