Branford Pediatrics
═ & Adolescent Medicine ═

784 E. Main St. Branford, CT 06405

Patient's Name: ____

Date Of Birth: ____

Cell Phone if 18 years or older: _________________________________

AUTHORIZED REPRESENTATIVE FORM

I, ______________________________, authorize the following people as my representatives in obtaining pertinent medical information regarding my child's/my own care.

I understand that **this does not constitute consent for treatment or allow access to patient records**, only that Private Health Information can be discussed with the parties mentioned below.

NAME	RELATIONSHIP
__________________________________	____________________________________
__________________________________	____________________________________
__________________________________	____________________________________

Consent given by: ______________________________ Signature: ____________________________

Relationship to Child: ________________________________ Date: ____________________ v 4 21