Branford Pediatrics
& Allergy

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: _____