Kathleen Ennabi Pediatrics

Affiliated with Children's Women's Physicians of Westchester, LLP

Authorization To Bring Child for Treatment

DATE:_______________________

I, ____parent/guardian of

child's name____

authorize the following individuals to bring my child to Kathleen Ennabi Pediatrics for treatment .

NAME/relationship to child____

Address____

NAME/relationship to child____

Address____

_

NAME/relationship to child____

Address____

Signature of Parent/Guardian____

Address of Parent/Guardian____

This authorization will be in effect for one year from the date above. It can be revoked by the parent /guardian at any time.