

TOWN AND COUNTRY PEDIATRICS MEDICAL AUTHORIZATION FOR TREATMENT

DATE: _____

I hereby authorize the physicians and nurse practitioner at Town and Country Pediatrics, in our absence, to provide required medical treatment, in the opinion of the provider acting on behalf of our child.

Printed Name of Child(ren)/DOB: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

I also authorize the following persons to authorize medical treatment for the above named child(ren).

Please drop this off at your child's Town and Country Pediatrics location or fax to:
Halsted office: 312-981-6312 or email officehalsted@townandcountrypeds.com
Glenview office: 847-998-8807 or email at officeglen@townandcountrypeds.com
Lincoln office: 773-478-4916 or email at officelinc@townandcountrypeds.com