APPROVED REPRESENTATIVES FOR PATIENT SERVICES

The following person(s) may bring my child, _____ to _____ Clinic for services. I understand that identification must be shown by the representative when bringing the child to see the Provider.

Name of Individual	Relationship to Patient
_____	_____
_____	_____
_____	_____

Signature of Parent/Guardian	Date
_____	_____

FORM NUMBER	ORIGINATON DATE	REVISION DATE	OBSOLETE DATE	REVIEW DATE
CL0005	6/12/2015			