248 PLEASANT STREET, SUITE 2600
CONCORD, NEW HAMPSHIRE 03301
Phone (603) 224-1929
Fax (603) 228-7114
www.concordpediatricsnh.com

Verbal Authorization

Please Print Clearly

Patient Name _____ **DOB** _____

Mailing Address _____ , _____, _____ _____

Street City State Zip code

I, _____ **(Parent or Guardian) give permission for the following to speak with the providers or staff at Concord Pediatrics PA regarding the health for my child.**

This authorization will be effective until I revoke it in writing, or my child turns 18.

Whichever should come first.

Authorized Person _____**Relationship to Patient** _____

Authorized Person _____**Relationship to Patient** _____

Authorized Person _____**Relationship to Patient** _____

Parent's Printed Name _____**Relationship to Patient** _____

Parent's Signature _____ **Date** _____