Westerville Pediatric Specialists, Inc.
575 Westar Crossing, Suite 101
Westerville OH 43082
Tel: 614/508-2223
Fax: 614/508-2233

AUTHORIZATION FOR STEP-PARENT TO SEEK MEDICAL CARE

Patient(s) name(s): _____

_____

_____

The following **step-parent(s)** named below is authorized to schedule appointments and seek care for well child routine visits including immunizations, illness or injury for the above named patient(s) with the physicians and nurse practitioners of Westerville Pediatric Specialists, Inc. Please be advised the individuals named below are people who will have access and knowledge of private health information:

_____

I _____, parent/legal guardian of the above-named patient(s) give permission for the above-named authorized individuals to seek medical care in my absence.

_____

Printed Name **Signature** **Date**

Notary: _____ Witness: _____

County: _____ State: _____ Expires: _____