COMMUNITY CARE PHYSICIANS, P.C.

COMMUNITY CARE PEDIATRICS - CLIFTON PARK – 942A ROUTE 146, 1783 RT. 9, CLIFTON PARK NY 12065

I, _____ authorize _____ to seek and consent to medical care for

(Name of parent/Legal Guardian) (Name of person given consent)

_____ DOB: _____ at Community Care Pediatrics - Clifton Park.

(Name of Patient) (Date of Birth)

Starting:_____ to:_____

(Date the consent was signed) (Expiration Date)

Date:_____ Signature:_____

Relationship to Patient:_____