Town and Country Pediatrics and Family Medicine, PC
380 Main Street, Watertown, CT 06795
860-274-8891 860-274-8895 (fax)

MEDICAL AUTHORIZATION FORM

I, ______________________________, being the parent and/or legal guardian of ______________________________ (hereinafter, my child(ren)) do hereby authorize ______________________________ to seek and obtain medical care for my child(ren) in the event that my child(ren) need(s) medical care.

I agree to be financially responsible for the cost of any medical care provided to my child(ren) under this authorization.

______________________________ ______________________________

Name of Parent and/or Legal Guardian Signature of Parent and/or Legal Guardian

Date______________