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Permission to Obtain Medical Information / Pick up Prescriptions

I, ____________________________, am the legal parent/guardian of
Parent/Guardian Name

______________________________, date of birth: __________________.
Patient Name

I authorize the following individual(s) to bring my child for visits with Bee Caves Pediatrics, and permit them to be present in the exam room when my child is treated:

Name: __________________________________

Name: __________________________________

Patient Relation: ________________________________

***Parent Signature: ______________________________Date: ________________**