



CLIFTON PARK PEDIATRICS – 1783 RT. 9, SUITE 101 – 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 Clifton Park Pediatrics.
(Name of Patient) (Date of Birth)

Starting: _____ to: _____
(Date the consent was signed) (Expiration Date)

Date: _____

Signature: _____

Relationship to Patient: _____