Pediatrics, C & C Medical Associates

This is to verify that we/I hereby authorize the doctors from C & C Medical Associates Pediatric Clinics, WA. or those by them designated including ancillary personnel to evaluate, diagnose, treat, and otherwise care for including all necessary tests or procedures, while brought to them by a person other than ourselves or when reporting to them unaccompanied, whether in their offices or elsewhere, my child(ren) whose name(s) and date(s) of birth follow:

	NAME:	DATE OF BIRTH
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

This permission is valid until revoked by notice to C & C Medical Associates Pediatric Clinics in writing.

Signed: _____

Date: _____