



Premier Pediatrics

Where Kids Come First

Date _____

I give my permission for _____

to authorization treatment for my child _____

I also authorize Premier Pediatrics to discuss my child's protected health information with the above named individual.

This permission is for the time period of _____ through

Name _____

Relationship to child _____

Signature _____

Mark Gilchrist, MD ♦ Stephanie Crum, MD

Board Certified Pediatrics

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