



2380 S. Eola Rd., Suite 102
Aurora, IL 60503
Phone: 630-978-PEDS(7337)
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Responsible Party Authorization

Patients Names:

Date of Birth:

1. _____

2. _____

3. _____

4. _____

I hereby authorize the following individuals to bring my children whom I am responsible for to the clinic without my presence.

Name:

Relationship to Patients:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

Signature of Responsible Person

Print Name of Responsible Person

Date