Decerina Uy MD, P.C.

649 Route 25A Suite 3
Rocky Point, New York 11778
Tel. No.(631) 509-0671; 476-7575
Fax No. (631) 509-0672

Authorization to Accompany Child

Patient Name: _____ _____
Date of Birth

_____ _____
Date of Birth

_____ _____
Date of Birth

I (We) hereby authorize _____ to accompany my/our child(ren) to the office of Decerina Uy MD, P.C. in my absence. I (We) also authorize Dr. Decerina Uy and her personnel to deliver medical services to my child.

Any Personal Health Information relating to said child(ren) pertinent to the visit may be disclosed.

Name of parent/guardian (print): _____

_____
Signature of Parent/Guardian Date

_____
Witness Date

This authorization expires on _____
Date