

Valencia Pediatric Associates
27867 Smyth Dr. Suite 100
Valencia, CA 91355
TEL (661) 294-2229 FAX (661) 294-8399

Designee Authorization Form

Date: _____

I, _____ parent /legal guardian of _____

designate _____ to act on my behalf and to obtain treatments and/or
discuss my child's health care with Valencia Pediatrics.

This authorization shall be in effect from _____ to _____ or until further notice

Signature of Parent