**Sunshine Pediatrics of Central Florida, PL**
**210 Lookout Place**
**Maitland, FL 32751**
**Phone 407-215-0400**
**Fax 407-215-0402**

I,_____
(PARENT/LEGAL GUARDIAN)
AM HEREBY GIVING PERMISSION FOR:
_____

DRIVER'S LICENSE
NUMBER_____

TO BRING MY CHILD/CHILDREN TO **SUNSHINE PEDIATRICS OF CENTRAL FLORIDA, PL** AND TO RECEIVE MEDICAL TREATMENT AND ADVISE DURING MY ABSENCE.

| CHILD / CHILDREN'S NAME | DATE OF BIRTH |
|---|---|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |
| 4. _____ | _____ |
| 5. _____ | _____ |

I ALSO AM PROVIDING MY CURRENT INSURANCE INFORMATION ALONG WITH MY COPAYMENT OR
FULL PAYMENT FOR THE SERVICES RENDERED. I ALSO UNDERSTAND IF **SUNSHINE PEDIATRICS OF CENTRAL FLORIDA, PL** IS UNABLE TO OBTAIN PAYMENT FROM MY INSURANCE COMPANY I AM RESPONSIBLE FOR PAYMENT IN FULL FOR SERVICES RENDERED TO MY CHILD/CHILDREN WHILE UNDER THE CARE OF THE ABOVE NAMED PERSON.

I ALSO GIVE PERMISSION FOR **SUNSHINE PEDIATRICS OF CENTRAL FLORIDA, PL** TO OBTAIN ANY MEDICAL RECORDS FROM ANY PHYSICIAN/FACILITY PERTAINING TO THE ABOVE NAMED CHILD/CHILDREN.

_____ _____
PARENT/LEGAL GUARDIAN'S SIGNATURE DATE

THIS AUTHORIZATION IS ONLY VALID FOR 1 YEAR FROM THE DATE OF NOTARIZATION.

_____ _____
NOTARY SIGNATURE DATE

_____
PRINT NAME