AUTHORIZATION FOR CAMP/SCHOOL FORMS

☐ School Forms
☐ Camp Forms
☐ Immunizations
☐ Other

Patient Name: _____

Date of Birth: _____

Mailing Address:

Parent: _____

Street: _____

City/State/Zip _____

Daytime phone number: _____

Check one: ☐ pick-up ☐ mail

RECORDS CANNOT BE FAXED

For Office use only
Cash: _____
Check: _____
Credit Card: _____

X _____
(Parent/Guardian Signature)

Account#: _____ Responsible Party: _____

Patient: _____ Amount Paid: _____

Doctor: _____

CASH: _____
CHECK: _____
CREDIT CARD: _____