Northeast Mississippi Health Care Inc.
12 East Brunswick Street
Byhalia, MS 38611
(662) 838-2163

Pediatric Authorization

I ____________________________(parent), give the following person(s) permission to knowingly and voluntarily bring my child ______________________________(patient) to Northeast Mississippi Health Care Inc., for medical/dental treatment:

- Mother ____
- Father ____
- Brother ____
- Sister ____
- Grandparent ____
- Others/ Relationship:

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______ I agree to allow the above listed person(s) bring my child to the doctor.

______ I do not wish for anyone other than myself to bring my child to the doctor

Any of the listed above person(s) must be of the age 18 years and older.

I understand that I have the right to revoke this authorization at any time, and I must deliver a written notice of cancellation to the front desk at either of the following clinics: Byhalia Family Health Center, Byhalia Family Dental Center, Mt. Pleasant Family Health Clinic, or Desoto Community Health Center. I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer will be protected by the privacy regulations.

______________________________ ______________________

Signature of the Parent/Representative/Guardian Date