Barney Softness, M.D., F.A.A.P.
Suzanne Rosenfeld., M.D., F.A.A.P.
Michael Rosenbaum, M.D., F.A.A.P.
Adine Brandes, M.D., F.A.A.P.
Lisa Thebner M.D., F.A.A.P.

450 West End Avenue • New York, NY 10024 • 212-769-3070 • Fax: 212-769-4703
2 Fifth Avenue • New York, NY 10011 • 212-353-0072 • Fax: 212-353-1621

Authorization to Consent to Medical Treatment of Minor

Name(s) of Minor(s)

_____DOB _____

_____DOB _____

_____DOB _____

_____DOB _____

I hereby authorize _____ (caregiver)

_____ (grandparent)

(an adult, 18 years or older, into whose care the minor has been entrusted) to consent for medical care for the above named minor(s) in accordance with New York State provision as deemed necessary by a licensed physician of West End Pediatrics.

Signed_____Date_____

Print Name_____

Specify Relationship to minor(s):
( ) Parent(s) with legal custody
( ) Guardian(s) with legal custody

This authorization will remain in effect until **revoked in writing.**