



Pediatric Cardiology Associates of WNY, LLC  
936 Delaware Avenue, Suite 100  
Buffalo, NY 14209

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Acct #: \_\_\_\_\_

DOB: \_\_\_\_\_

I, \_\_\_\_\_ (*patient or parent/guardian*), give permission to the following person(s) to bring the patient in for medical treatment. This is to include any discussions with the physician, until this document is retracted.

**Name (please print)**

**Relationship to patient**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

\_\_\_\_\_  
*Signature of Patient or parent/guardian*

Expiration Date: \_\_\_\_\_  
*Two years from date at top*

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*Office Use Only:*  
Approved by: \_\_\_\_\_ Title: \_\_\_\_\_  
Date: \_\_\_\_\_