



DALLAS PEDIATRICS

& ID ASSOCIATES

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Request for Authorized Persons to bring my children for treatment

I _____ give Dallas Pediatrics & Infectious Disease Associates and its employees to provide treatment for my child when the child is brought in by the following **Authorized Persons** individuals, I also understand that the person accompanying the child must be able to provide a government issued photo identification like Drivers license, Texas State ID, Passport etc. Student IDs are not accepted.

Authorized person name: _____ ID No: _____ St: _____

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Authorized person name: _____ ID No: _____ St: _____

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Authorized person name: _____ ID No: _____ St: _____

Further, I understand and agree that Dallas Pediatrics & Infectious Disease Associates reserves the right to refuse to see my child unless accompanied by an Authorized Person.

Patient Name: _____ Date of Birth: _____

Parent Name: _____ Signature: _____

Date: _____

