1473 N. Lee Trevino
El Paso, TX, 79936
Phone: 915-280-9267
Fax: 915-249-4262

Authorization for Other Caregivers

I give the following person/persons permission to obtain care for my child at Desert Bloom Pediatrics in my absence. I also give this person/persons permission to contact Desert Bloom Pediatrics to obtain any medical advice, medical information/records, and/or insurance/billing information necessary for said child. This authorization shall remain effective unless revoked in writing by the undersigned.

Name and DOB of patients: _____

Name(s) of authorized individuals: _____

_____

Relationship to child: _____

Parent/guardian signature: _____

Date: _____