



# NORTHWEST PEDIATRICS INC.

**DUBLIN**

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**UPPER ARLINGTON**

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## PERMISSION TO FAX

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

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

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

I \_\_\_\_\_, give Northwest Pediatrics permission to fax:  
Parent Name

\_\_\_\_\_ Vaccine Record

\_\_\_\_\_ Physical Form

\_\_\_\_\_ Other: \_\_\_\_\_

To: \_\_\_\_\_ Fax Number: \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Print Name