



Northwest Pediatrics Inc.

I (WE) _____ authorize Northwest Pediatrics
Print Name of Legal Guardian(s)

of Columbus, Ohio and its personnel to allow authorized individuals to pick up

Prescriptions for my child, _____.

I (WE) Authorize the following people to Pick up my child's Prescription:

Name: _____ Relationship: _____

Contact Number: _____

Name: _____ Relationship: _____

Contact Number: _____

Name: _____ Relationship: _____

Contact Number: _____

Signature of Legal Guardian

Date

Relationship to Patient: _____