CONSENT FOR MESSAGE AUTHORIZATION

I authorize Delta Pediatrics, its representatives, physicians and staff to leave messages related to my child's healthcare on a recorder such as voicemail or answering machine at the following phone number (s):

1. _____

2. _____

3. _____

_____ _____

Signature of Parent/Legal Guardian Date

*** IF PATIENT IS UNDER 18 YEARS OF AGE, A PARENT OR LEGAL GUARDIAN MUST SIGN***