

Mountain View Internal Medicine & Pediatrics  
Vipul Parikh, M.D.

Pediatric Patient Information

Additional Caregiver Authorization

I hereby authorize the individual named below to accompany my child to appointments at Mountain View Internal Medicine & Pediatrics:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relation to child: \_\_\_\_\_

Time period this authorization is valid, up to 12 months: \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_

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

\*Any individual obtaining care on your behalf for your child must be over the age of 18\*