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# MEDICAL POWER OF ATTORNEY
# FOR ADULT PATIENTS

This medical power of attorney is my authorization for
(Name) ________________________________
(Relationship)________________________________; to discuss and be a part of my medical care and for Pediatric Associates, P.A. to discuss treatment or examination by any of its physicians or nurse practitioners while I am in their care. This authorization is valid for one year or until __________________.

Print Name: ________________________________
Patient signature: ________________________________
Date: ________________________________

STATE OF FLORIDA
COUNTY OF ESCAMBIA

SWORN TO AND SUBSCRIBED BEFORE ME on
This ______________________ day of 20___.

________________________________
Notary Public
My commission expires: _______________