



Date \_\_\_\_\_

We realize there are times when a parent/guardian cannot accompany their child to an appointment. In these situations we ask that you please list any person(s) that are authorized to give consent to treat your child while they are in his/her care. This includes the sharing of all necessary medical information with this individual regarding the child's medical history as well as present treatment and procedures.

In the event your child is scheduled for a well child exam we ask that a parent be present.

Child(ren)'s Name \_\_\_\_\_  
\_\_\_\_\_

Authorization is given to:

\_\_\_\_\_ for \_\_\_ visits, \_\_\_ medical records, \_\_\_ prescription(s), \_\_\_ phone calls.

\_\_\_\_\_ for \_\_\_ visits, \_\_\_ medical records, \_\_\_ prescription(s), \_\_\_ phone calls.

\_\_\_\_\_ for \_\_\_ visits, \_\_\_ medical records, \_\_\_ prescription(s), \_\_\_ phone calls.

\_\_\_\_\_ for \_\_\_ visits, \_\_\_ medical records, \_\_\_ prescription(s), \_\_\_ phone calls.

Parent/Guardian Name \_\_\_\_\_ (Print)

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