PERMISSION TO TREAT A MINOR

I ______________________ give permission to my child ________________________
(Name of guardian) (Name of Child)
to attend his/her illness appointment alone without my presence and authorize treatment for my child in accordance with the office policy of Pediatric Health Care Associates. This includes providing a history of present illness, disclosure of protected health information, and responsibility for relaying any diagnosis, treatment plan, or prescription(s) to the parent or legal guardian mentioned above. I agree to be available by phone and to be financially responsible for all copays and coinsurance. This authorization is effective on: _____________________ and expires ________________________.
(Today's date) (Date Authorization is No Longer Valid)

Child's Health Information
Current prescribed or over-the-counter medications and dosages:
Medication: ____________________________ Dosage: _____________________
Medication: ____________________________ Dosage: _____________________
Medication: ____________________________ Dosage: _____________________
Medication: ____________________________ Dosage: _____________________

Allergies, illnesses or other comments: ____
____
____

Emergency Contact Information for Parents/Guardians
Where/how can you be contacted in case of emergency? __________________________
Phone: _____________________________
Comments:____
____

Temporary Guardian Information
Name: ________________________________ Phone: ___________________________
Address: ____
Health Insurance Information

Insurance Information
Insurance Company:_________________________ Policy Holder: ___________________
ID Number: ________________________________ Group Number: ________________
Effective Date: ______________________________ Copay: _______________________
Parent or Legal Guardian's Signature: ________________________ Date:___________