AUTHORIZATION FOR TREATMENT OF MINOR NOT ACCOMPANIED BY PARENT OR LEGAL GUARDIAN

Name of Patient: _____ Date of Birth: _____

To: PEARL CITY MEDICAL ASSOCIATES, INC.

☐ There may be instances when I will not be able to accompany my child when he/she needs medical care. In those instances, I have authorized the following individuals to accompany my child to your office:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

☐ I also authorize you to verbally provide information regarding the treament of my child to the above-named individuals, so that they are able to relay that information to me. Please limit the disclosure to that which is relevant to that specific visit.

☐ I permit my teenage child to be seen and treated by you, even when I am unable to accompany him/her.

☐ When my teenage child is unaccompanied, I authorize you to exercise your professional judgment in determining whether the results of the examination, plan of treatment, and other relevant information should be discussed at that time with him/her.

_____
Print Name of Parent/Legal Guardian

_____ _____
Signature of Parent/Legal Guardian Date