

PERMISSION TO ACCOMPANY A MINOR

l,	give permi	SSION to
(Name of Parent/Guardian)		(Name of Adult to be accompanying minor)
	(Child's Name and Date of	Birth)
(Name of Parent/Guardian) (Name of Adult to be accompanying minor) to accompany my child and authorize treatment for my (Child's Name and Date of Birth) child in accordance with the office policy of Midwest Medical Specialists. This includes bringing the child into		
the office of Midwest Medical Specialists, providing a history of present illness, disclosing protected health		
information, and witnessing any physical exam completed by the provider. This adult has the responsibility		
to present my child's valid insurance	card at the time of t	he appointment, and to relay any diagnosis,
treatment plan or prescription(s) to me the parent or legal guardian mentioned above. I agree to be available		
by phone if needed and to be financially responsible.		
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This authorization is effective from: _	to	
	(Today's Date)	(End Date)
Temporary Guardian Information:		
	Date of Birth:	Phone Number:
Address:		
Parent of Legal Guardian's Signature		Date:
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