PERMISSION TO ACCOMPANY A MINOR

I, _____, give permission to _____
(Name of Parent/Guardian) (Name of adult to be accompanying child)
to accompany my child _____ and authorize treatment for my
(child's name and DOB)
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 the appointment, and to relay any diagnosis, treatment plan or prescription(s) to the parent or legal guardian mentioned above. I agree to be available by phone if needed and to be financially responsible.

This authorization is effective from: _____ to _____.
(effective date) (end date)

Temporary Guardian Information:

Name: _____ Phone: _____
Address: _____

Parent/Legal Guardian's Signature: _____ Date:_____

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