Pinehurst Medical Clinic, Inc.

PERMISSION TO ACCOMPANY A MINOR

I, _____, may not always be able to accompany my minor child
(Name of Parent/Guardian)
for his/her medical visits. I, hereby, give permission to the persons listed below to accompany my child _____ and authorize treatment for my
(Child's name and DOB)
child in accordance with the policy of Pinehurst Medical Clinic, Inc. This includes bringing the child into the office of Pinehurst Medical Clinic, Inc., providing a history of present illness, disclosing protected health information, accompanying consented research study procedures, and witnessing any physical exam completed by the provider. I acknowledge the person accompanying my minor child has the responsibility to relay any diagnosis, treatment plan or prescription(s) to me. I agree to be available by phone and to be financially responsible for all copays and coinsurance.

Please list all persons to whom you grant this authorization.

_____	_____
(Name)	(Relationship)
_____	_____
(Name)	(Relationship)
_____	_____
(Name)	(Relationship)
_____	_____
(Name)	(Relationship)

This authorization will remain in effect until the parent or legal guardian revokes or until the minor child becomes 18.

Emergency Contact Information for Parents/Guardians:
How can you be contacted in case of emergency?

Phone: _____

Comments:_____
_____

Parent or Legal Guardian's Signature: _____

Date:_____