CHOPRA PEDIATRICS

# PERMISSION TO TREAT A MINOR

I _____ give permission to my child _____

(Name of guardian) (Name of minor child at least 16y of age)

to attend his/her illness appointment alone without my presence and authorize treatment for my child in accordance with the office policy of Chopra Pediatrics. This includes providing a history of present illness, disclosure of protected health information, making decisions about treatment, and responsibility for relaying any diagnosis, treatment plan, and prescription(s) to the parent or legal guardian mentioned above.

I agree to be available by phone at the time of the appointment and to be financially responsible for all copays and coinsurance. **I also understand that this does not include visits regarding ADHD**. Appointments that include the discussion of ADHD, ADHD follow ups, and refills of medication will require an adult parent or guardian (at least 18y of age) to be present.

This authorization is effective on: _____ and expires on _____.

(Today's Date) (Date Authorization is No Longer Valid)

**Emergency Contact Information for Parents/Guardians:**

Where/how can you be contacted in case of emergency?

_____

Phone: _____

**Alternate/Temporary Guardian Information**

Name: _____ Phone: _____

Address:

_____

**Parent or Legal Guardian's Signature**: _____ Date:_____