PERMISSION TO ACCOMPANY A MINOR

I, _____, give permission for the following adults:
(Name of Parent/Guardian)

- _____
  Name of Adult Accompanying Child | Phone Number | Relationship to Child
- _____
  Name of Adult Accompanying Child | Phone Number | Relationship to Child
- _____
  Name of Adult Accompanying Child | Phone Number | Relationship to Child

to accompany my child _____ and authorize
(child's name and DOB)
treatment for my child in accordance with the office policy of Chopra Pediatrics. This includes bringing the child into the office of Chopra Pediatrics, providing a history of present illness, disclosing protected health information, witnessing any physical exam completed by the provider, and making medical decisions about treatment of the patient. This adult has the responsibility to relay any diagnosis, treatment plan and prescription(s) to the parent or legal guardian mentioned above. I agree to be available by phone if possible at the time of the visit and financially responsible for all copays and coinsurance.

I ____ **DO** ____ **DO NOT** give permission for the above adults to make decisions regarding vaccines.

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

Emergency Contact Information for Parents/Guardians:
Where/how can you be contacted in case of emergency_____
Phone: _____
Comments:
_____
_____

Parent or Legal Guardian's Signature: _____Date_____