PERMISSION TO TREAT A MINOR

I _____ give permission to my child _____

(Name of guardian) (Name of child age 16-18 years)

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 a parent or guardian (over the age of 18) 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(Today's Date) (Date authorization is NO LONGER valid)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 contact in the case of an emergency?

_____

Phone: _____

Alternate/Temporary Guardian Information

Name: _____ Phone: _____

Address: _____

_____

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