PERMISSION TO TREAT A MINOR

I _____give permission to my child _____

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 visits ADHD.** Appointments that include the discussion of ADHD, ADHD follow ups, and refills of medication will require an adult parent or guardian (over age 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(Today's date) (Date Authorization is No Longer Valid)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 contacted in case of emergency?_____

Phone:_____

Alternate/temporary guardian information

Name:_____
Phone:_____

Address:_____

Parent or Legal Guardian's Signature:_____Date:_____

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