REG32

# AUTHORIZATION FOR MINOR CHILD ACCOMPANY

_____

**Patient Name:** **Date of Birth:**

I authorize the following individual(s) to accompany my child to his/her appointment(s).

**I do ___ do not** ___Allow Children's Specialized Hospital to verbally discuss and disclose medical information about my child's visit.

**I do ___ do not** ___ Authorize them to see all necessary medical records and make health care decisions of a routine nature.

The person bringing your child will need to present **photo identification** at time of service.

| **Person (s) Name:** | **Relationship to Patient:** |
|---|---|
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As the parent or legal guardian, I understand that I must present to the office, in person, to sign **any treatment plans, consent for medications or informed consents before any procedures can be performed for my child.** I further understand that it is my responsibility to provide payment or a source of payment on the day that services are rendered, even when this authorized person brings the child.

**This consent is valid for one year from date of signature unless I notify you in writing of my withdrawal.**

_____

(Print /Parent/Legal Representative Name)

_____ _____

(Signature of Patient/Parent/Legal Representative) (Date Signed)

_____ _____

(Children's Specialized Hospital Representative) (Date Signed)