Independence & Lee's Summit PEDIATRICS

PERMISSION TO ACCOMPANY A MINOR

I, _____ give permission to _____
(Name of Parent/Guardian) (Name of Adult to be accompanying minor)

to accompany my child _____ and authorize treatment
(Child's Name and Date of Birth)

for my child in accordance with the office policy of Independence Pediatrics, P.C. This includes bringing the child into the office of Independence Pediatrics, P.C., providing a history of present illness, disclosing protected health information and witnessing any physical exam completed by the provider. This adult has the responsibility to present my child's valid insurance card at the time of the appointment, and to relay any diagnosis, treatment plan or prescription(s) to me, the parent or legal guardian, mentioned above. I agree to be available by phone if needed and to be financially responsible for the visit and all charges.

This authorization is effective from:_____ and expires:_____.
(Today's date) (Date Authorization no longer valid)

Temporary Guardian Information:
Name:_____Date of Birth:_____Phone Number:_____
Address:_____

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