

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 HFM Pediatrics. This includes providing a history of present illness, disclosure of protected health information, receiving immunizations and responsibility for relaying any diagnosis, treatment plan, or prescription(s) to the parent or legal guardian mentioned above. I agree to be available by phone and to be financially responsible for all copays and coinsurance. This authorization is effective on:

_____ and expires _____.
(Today's Date) (Date Authorization is No Longer Valid)

Child's Health Information

Current prescribed or over-the-counter medications and dosages:

Medication: _____ Dosage: _____
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____

Allergies, illnesses or other comments: _____

Emergency Contact Information for Parents/Guardians:

Where/how can you be contacted in case of emergency? _____

Phone: _____

Comments: _____

Temporary Guardian Information

Name: _____ Phone: _____

Address: _____

Health Insurance Information

No change since last visit (*skip to next section*)

Insurance Company: _____ Policy Holder: _____

ID Number: _____ Group Number: _____

Effective Date: _____ Copay: _____

note: if you do not wish for the minor to become up to date on vaccinations OR if you have various concerns/questions, a parent/legal guardian **must be present.*

Parent or Legal Guardian's Signature: _____

Date: _____