Authorization to Accompany Patient

I, ____, give permission to all parties listed below
(Name of Guardian)

to accompany my child, ____ ___________
(Patient's Name) (Date of Birth)

and authorize treatment for my child in accordance with the office policies of First Choice Pediatrics . This includes bringing the child into the office, providing a history of present illness, disclosure of protected health information, witnessing any physical exam completed by the provider, 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.

The following are permitted to accompany patient and **MUST SHOW PHOTO ID AT CHECKIN**

________________________________ _____________________ _____________________
NAME PHONE RELATIONSHIP TO PATIENT

________________________________ _____________________ _____________________
NAME PHONE RELATIONSHIP TO PATIENT

________________________________ _____________________ _____________________
NAME PHONE RELATIONSHIP TO PATIENT

____ ___________
Parent/Legal Guardian Signature **Date**

____ ___________
Witness Signature **Date**