



*Excellence in
Orthopaedic Surgery
Since 1993*

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PERMISSION TO ACCOMPANY A MINOR

I, _____, give permission for _____
(Name of Parent/Guardian) (Name of adult to accompany child)

To accompany my child, _____, whose date of birth is _____

And authorize treatment for my child. The accompanying adult's relationship to the child is _____.

This permission and authorization include bringing the child into the office of Advanced Orthopaedic Associates, P.A., providing a history of present illness, disclosing protected health information, signing applicable paperwork, and witnessing any physical exam completed by the provider. This accompanying adult has the responsibility to relay 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 reasonable charges in connection with care and treatment rendered to my child.

This authorization shall remain effective from _____ to _____.
(effective date) (end date)

(If no dates are specified, this authorization will expire one year after the date signed unless terminated in writing by the undersigned)

Parent or Legal Guardian's Signature Date

Contact Information for Parent(s)/Guardian(s):

Phone number(s): _____

Address: _____

Comments: _____

Please bring to the office for a copy to be scanned to the minor's chart