Excellence in Orthopaedic Surgery since 1993

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Main - West Office
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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