Greenwich Pediatric Associates

Authorization to Accompany Minor

Designation From Date: _____/_____/_____

I, ______________________________, parent/legal guardian of ___________________________ , give the following persons permission to accompany above listed child to visits and to make decisions regarding the necessary and or routine treatment, including but not limited to examinations, injection, immunization, medication and/or diagnostic procedures, including x-ray or laboratory analysis. I also designate these persons to receive Protected Health Information (please see our Notice of Privacy Practices) including but not limited to any records of treatment, forms, and prescriptions. I understand that only myself and those listed below will have the authority to authorize treatment and receive Protected Health Information.

I also authorize treatment (except for immunizations/injections) of my mature teen (16 years and older) without requiring the presence of an adult. However if my teen needs immunizations and comes alone, a parent/guardian must be available by phone for verbal consent.

Please note that a stepparent or grandparent does NOT have the legal right to consent for care unless designated below.

Name	Relationship to Patient	Phone Number
__________________________	______________________	_________________
__________________________	______________________	_________________
__________________________	______________________	_________________
__________________________	______________________	_________________

I understand that any person not listed above bringing a patient who is a minor for treatment must have a letter of consent from me or treatment may be refused or delayed. I understand that in an emergency situation, efforts will be made to contact me prior to the rendering of treatment, but that emergency medical treatment will not be withheld if I cannot be reached.

This authorization will remain in effect unless revoked in writing. I have read all the information on this sheet and have provided the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify Greenwich Pediatric Associates of any changes in the health status of my children or the above information.