

Authorization for Treatment of Minor Patient Who is Unaccompanied by Parent/Guardian

Name of Patient:

Date of Birth:

Ideal Pediatric and Adolescent Care recognizes there are times when a parent or legal guardian may not be able to accompany a child to an appointment and must (1) rely on a family member or friend to accompany the child or (2) may choose to allow the child (age 16 or older only) to attend the appointment unaccompanied by an adult. We understand these circumstances; however, we must have your written authorization allowing an adult you specifically identify to accompany your child or permitting the child to attend alone. If you provide consent for us to treat your unaccompanied child, you understand that care will proceed at the discretion of the healthcare provider.

The person accompanying the child must be an adult (age 18 or above) and must present a photo identification at the time of the visit.

ONLY PARENT/GUARDIAN MAY ACCOMPANY CHILD FOR TREATMENT AT IDEAL PEDIATRIC

I, _____, **DO NOT** authorize anyone other than the child's father, mother, and/or legal guardian to accompany my child to Ideal Pediatric for the provision of medical services.

AUTHORIZATION TO PERMIT CERTAIN ADULTS TO ACCOMPANY CHILD FOR TREATMENT:

I, _____, hereby authorize the following adults(s) to accompany my child to Ideal Pediatric for medical services, and to view or discuss my child's Protected Health Information (PHI) when accompanying my child.

Name(s) of authorized adult(s): *Please print*

Last name, First name

Relationship to patient

Last name, First name

Relationship to patient

Last name, First name

Relationship to patient

This/These individual(s) are able to authorize medical services, including : x-ray lab tests

CONSENT TO TREAT UNACCOMPANIED MINOR (age 16 or older) AT Ideal Pediatric:

I, _____, request and authorize Ideal Pediatric and its personnel to deliver medical care and services to my MINOR CHILD identified above.

I/we may be reached at the following telephone numbers during my child's appointment(s):

Parent/Guardian's Name

Primary Contact Number

Alternate Contact Number

Parent/Guardian's Name

Primary Contact Number

Alternate Contact Number

PRINT NAME

RELATIONSHIP

SIGNATURE

DATE