Children's Clinic, P.A

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Authorized Adults

Patient Name _____ Date of Birth_____

Parent/Guardian_____ Date of Birth_____

In the event that I, the parent/legal guardian, cannot personally accompany my child to his/her appointment with the Children's Clinic P.A., I authorize the following people to act in my place. This authority covers the ability to sign for any vaccines/medications that may need to be given in my absence.
This does NOT include the authority to request records, or to make any changes in my child's account.

Name _____ Relation _____

Name _____ Relation _____

In the event that an Authorized Adult is not able to attend, I grant Children's Clinic P.A. permission to treat my child without an adult present. This authorization is limited to general treatment only, no medications or vaccines will be given at the time of service.

YES □ NO □

Signature _____Date of Authorization_____

Unless pertaining to the visit where the patient is accompanied by a third party, I understand that at no time will Immunization Records, Chart Records, Prescriptions, School/Camp Forms, or any other documentation will be released to any individual other than myself or the alternate legal guardian without WRITTEN permission each time that said records are needed.
Please be aware that once that permission is given, it is only valid for a one time pick up, and Proof of Identification of the individual picking up said records will be required.
Thank You