Pediatric Wellness of Northern New York

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PERMISSION FOR TREATMENT OF MINOR

(PLEASE FILL OUT COMPLETELY)

Parent's Name: ____

Address: _________________________________City: ___________________ State: ____ Zip: _______

Home Phone Number: __________________________ Cell Phone Number: _______________________

Name of Child: ____ Date of Birth: ____________________

I, ____ authorize the below mentioned person(s), to act on my behalf in my absence for the patient listed above.

Name: __________________________________ Relationship: ________________ # ________________

Name: __________________________________ Relationship: ________________ # ________________

Name: __________________________________ Relationship: ________________ # ________________

Name: __________________________________ Relationship: ________________ # ________________

DATES OF AUTHORIZATION

☐ Indefinitely OR Beginning _______ - _______ - _______ Ending _______-_______-_______

CHECK ALL THAT APPLY

☐ TREATMENT ☐ PRESCRIPTIONS ☐ APPOINTMENT SCHEDULING

☐ VACCINE ☐ VACCIINE ☐ RECORDS ☐ PAYMENTS

☐ OTHER ____

SIGNATURE: ____ DATE: __________________

WITNESS: ____ (Must be witnessed by office staff.)

*Please remember to have above mentioned person bring photo I.D. and the patients' Insurance Card.