Primary Care Partners
Affiliated with
Atlantic Health System

Care Center Name:_____

Authorization to Bring a Minor

This authorization form is to be used when someone other than the parent or legal guardian will be bringing a minor to the physician's office.

Please check off all that apply

Child's Name	Date of Birth	Evaluation	Treatment	Admin of Vaccines

I hereby provide permission for the following person to bring my child(ren) to the office for the services that I have checked off above.

Name	Relationship to Child (ren)	Expiration Date

I understand that when the person(s) identified above take my child to Primary Care Partners, _____(Care Center Name) for a medical problem, my child(ren)'s protected health information that the medical provider determines relevant to the office visit may be disclosed to this person.

I understand that when the person(s) identified above takes my child(ren) for a well visit or for treatment of a medical problem, that this person may need to consent for my child(ren) to receive medical services that the medical provider determines necessary for the care and treatment of my child(ren). I hereby authorize the person(s) listed above to provide consent for the provision of the medical services stated above to my child(ren) by the Medical Providers of Primary Care Partners, _____(Care Center Name).

_____ _____
Name of Parent/Legal Guardian Signature

_____ _____
Relationship to Child(ren) Date

This authorization shall be valid for each visit that the person(s) identified above takes your child(ren) to Primary Care Partners, _____, office unless you provide an expiration date OR written notice of revoking authorization to the Primary Care Partners Care Center list above.

Initials