Permission for Treatment of a Minor

As the custodial parent of _____,
Minor Patient's Name

I give my permission for Pediatric Associates of Fairfield, Inc., to render medical services in my absence when my child is accompanied by any one of the following individuals:

1. _____
Name/Relationship Phone #

2. _____
Name/Relationship Phone #

3. _____
Name/Relationship Phone #

4. _____
Name/Relationship Phone #

The above named authorized individual should be prepared to present photo identification at time of service.

Medical services include but are not limited to: routine care, urgent care, immunization.

I understand it is my responsibility to provide accurate insurance information to the office and agree to be financially responsible for payment of all charges incurred.

This authorization will remain in effect until revoked in writing.

Signature _____ Date _____
Custodial Parent

1-2012/ljm/tc