PERMISSION TO ACCOMPANY AND/OR TREAT A MINOR

Permission to Accompany:

I, _____, give permission to _____ to accompany my child
(Name of Parent/Guardian) (Name of adult to be accompanying child)

_____ and authorize treatment for my child in accordance with the office policy
(child's name and DOB)

of Ohio Hills Health Centers. This includes bringing the child into the office of OHHC, providing a history of present illness, disclosing protected health information, and witnessing any physical exam completed by the provider. This adult has the responsibility to relay any diagnosis, treatment plan or prescription(s) to the parent or legal guardian mentioned above. I agree to be available by phone and to be financially responsible for all copays, deductibles, and coinsurance.

This authorization is effective from: _____ to _____.
(effective date) (end date)

Permission to Treat:

I, _____ give permission to my child _____ to attend
(Name of parent/guardian) (Name of child age 16-18 years)

his/her illness appointment alone without my presence and authorize treatment for my child in accordance with the office policy of Ohio Hills Health Centers. This includes providing a history of present illness, disclosure of protected health information, and responsibility for relaying any diagnosis, treatment plan, or prescription(s) to the parent or legal guardian mentioned above. I agree to be available by phone and to be financially responsible for all copays, deductibles, and coinsurance.

This authorization is effective from: _____ to _____.
(effective date) (end date)

Child's Health Information:

Current prescribed or over-the-counter medications and dosages:

Medication: _____ Dosage: _____
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____

Allergies, illnesses, or other comments:

_____

Emergency Contact Information for Parents/Guardians:

Where/how can you be contacted in case of emergency?

_____

Phone: _____

Comments:_____

Temporary Guardian Information

Name: _____ Phone: _____

Address: _____

Health Insurance Information ❒ No change since last visit

Insurance Company: _____ Policy Holder: _____

ID Number: _____ Group Number: _____

Effective Date: _____ Copay: _____

Parent/Guardian Signature_____ Date_____

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