Reston Pediatrics

PERMISSION FOR TREATMENT OF A MINOR

WHEN ACCOMPANIED BY SOMEONE OTHER THAN THEIR PARENT OR LEGAL GUARDIAN

Parent/Legal Guardian Name: _____

Street Address:_____ City, State, Zip Code: _____

Home Phone Number:_____ Cell Phone Number:_____

I, _____, do hereby authorize the below-mentioned person to act on my behalf for the patient (s) listed below.

Name of the Person Authorized:_____

Relationship to Child: _____

Name of Child: _____ Date of Birth: _____-_____-_____

Street Address: _____

City, State, Zip: _____

DATES OF AUTHORIZATION

Beginning: _____-_____-_____ Ending: _____-_____-_____ ☐ Indefinitely

CHECK ALL THAT APPLY

☐ Treatment ☐ Access to Records (charts/forms) ☐ Labs/X-Ray Results

☐ Vaccines ☐ Appointment Scheduling ☐ Prescription

_____ _____

Signature of Patient or Personal Representative Date

**Reminder to have the above-mentioned person bring a photo I.D. and the patient's insurance card.*
**Co-payment must be paid at the time of service.*