



PERMISSION TO TREAT A MINOR

I, _____, parent or legal guardian
(Name of parent/legal guardian)

of _____, give permission for
(Name of child/ren)

_____ to authorize medical treatment for my
(Name of adult to be accompanying child)

Child(ren) listed above.

This may include bringing the child into the office of *Chappaqua Pediatrics*, providing a history of present illness, disclosure of protected health information, witnessing any physical exam completed by the provider, and being responsible for relaying any diagnosis and treatment or prescriptions to the parent or legal guardian mentioned above.

This authorization is effective as of today, _____ and expires

(Date on which this authorization is no longer valid)

Signed,

(Signature of Parent/Legal Guardian)