

**Authorization by Parent or Legal Guardian for Another Person to Bring Minor to Physician’s Office**

**Names of Children**

**Dates of Birth**

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**I hereby provide permission for the following persons to bring my child(ren) to the office.**

**Names**

**Relationship to Child(ren)**

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I understand that when the person(s) identified above takes my child to Advocare Society Hill Pediatrics for a medical problem, the part of my child(ren)’s protected health information that the medical provider(s) 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 provide consent for my child(ren) to receive medical services the health care provider(s) 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 following medical services to my child(ren) by the medical providers of Advocare Society Hill Pediatrics.

**Evaluation**

**Treatment**

**Administration of vaccines**

\_\_\_\_\_  
Name of parent or 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 Advocare’s office unless you provide written notice to the Advocare Care Center listed above that you are revoking authorization.