Independence & Lee's Summit PEDIATRICS

PERMISSION TO TREAT A MINOR

I, _____ give permission to my child _____
(Name of Parent/Guardian) (Name of Child age 16-18 years old)

_____ to attend his/her illness appointment alone without my presence and
(Date of Birth)

authorize treatment for my child in accordance with the office policy of Independence Pediatrics, P.C. This includes providing a history of present illness, disclosure of protected health information and responsibility for relaying and diagnosis, treatment plan, or prescription(s) to the parent or legal guardian mentioned above. I agree to be available by phone if needed and to be financially responsible for the visit and all charges.

This authorization is effective on:_____ and expires:_____.
(Today's date) (Date Authorization no longer valid)

*A valid insurance card must be presented at the time of check-in for **ALL** appointments. Your child is expected to provide their insurance card if they are unaccompanied at their visit. If this is not feasible, please make arrangements with our office prior to the appointment.*

Parent or Legal Guardian's Signature:_____ Date:_____