AUTHORIZATION TO ACCOMPANY MINOR PATIENT TO APPOINTMENTS

Apply Patient Label

I, _____, the legally authorized representative of

_____ _____, give permission
(Patient Full Name) (Date of Birth)

to _____ _____, to take my child
(Name) (Relationship to Patient)

to appointments in the _____ of Phoenix Children's.
(Specify Department)

I understand this authorization is for routine care only, including examination and non-invasive testing, and that immunizations, diagnostic tests or procedures will not be performed without my authorization, except under emergency circumstances. I further authorize this Department to disclose pertinent medical information regarding my child's appointment(s) or treatment(s), including necessary follow-up instructions, to the individual identified herein.

Revocation and Expiration of Authorization: This authorization will expire automatically one (1) year from the date signed below, unless I revoke it sooner in writing.

SIGNATURE

Signature of Patient's Legally Authorized Representative	Date Time
Printed Name of Patient's Legally Authorized Representative	Relationship to Patient
Witness Signature	Date Time
Witness Printed Name	