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E-Mail: contact@batteryparkpediatricdentists.com

Permission to Accompany a Minor

I, _____, give permission to _____
(Name of Parent/Guardian) (Name of adult to be accompanying child)

to accompany my child _____ and authorize treatment for my

(child's name and DOB)

child in accordance with the office policy of BPPD. This includes bringing the child into the office of BPPD, providing a history of present illness, disclosing protected health information, accompanying and signing for consented procedures, and witnessing any exam completed by the provider. This adult has the responsibility to relay any diagnosis, treatment plan or prescription(s) to the parent or legal guardian mentioned above. I agree to be available by phone and to be financially responsible for all copays and coinsurance.

This authorization is effective from: _____ to _____.
(effective date) (end date)

Emergency Contact Information for Parents/Guardians:

Where/how can you be contacted in case of emergency? _____

Phone: _____

Comments: _____

Temporary Guardian Information

Name: _____ Phone: _____

Address: _____

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