Pediatric Associates
of Lewiston
Serving the Community Over 50 Years!

# Authorization – Non-Parent/Guardian to Accompany Patient

**Patient Name: _____**

**DOB: _____**

Periodically there may be times when you are unable to bring your child to the office for an appointment and need to rely on a family member or friend. We understand these circumstances; however, we must have a written authorization letter allowing this person to accompany your child.

This authorization gives the person permission to contact the office for medical advice, schedule appointments, bring your child in, speak to the doctor, give authorization for treatment, vaccinations, medications, procedures and make general health decisions.

I, _____, give the person listed below permission to bring my child to Pediatric Associates of Lewiston, PA and to discuss and share medical information about my child. I further authorize them to see all necessary medical records and make health care decisions of a routine nature as determined at the sole discretion of the Pediatric Associates of Lewiston provider.

I also give them authority to make more serious or urgent health care decisions in the event I cannot be reached or where it is of an emergency nature where there is not sufficient time to seek out my specific consent.

_____ _____
Name of Person (allowed to bring child) Relationship to Patient

_____ _____
Name of Person (allowed to bring child) Relationship to Patient

_____ _____
Name of Person (allowed to bring child) Relationship to Patient

X_____ _____
***Signature of Parent/Guardian** **Date**