



Pediatric Associates

of Lewiston

Serving the Community Over 50 Years!

Non-Parental Caretaker Authorization

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 adult person 18+ to accompany your child.

This authorization gives the adult person 18+ 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 adult person 18+ 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 Adult Person 18+ (allowed to bring child) Relationship to Patient

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X _____

***Signature of Parent/Guardian Date**
(Signature of Patient if 18 years and older)