PRIMARY CARE PARTNERS

_____
Care Center Name

Authorization by Parent or Legal Guardian for Another Person to Bring Minor to Physician's Office

Names of Children	**Dates of Birth**
_____	_____
_____	_____
_____	_____

I hereby provide permission for the following persons to bring my child(ren) to the office.

Names	**Relationship to Child(ren)**
_____	_____
_____	_____
_____	_____

I understand that when the person(s) identified above takes my child to Primary Care Partners for a medical problem, the part of my child(ren)'s protected health information that the medical provider(s) determines relevant to the office visit may be disclosed to this person.

I understand that when the person(s) identified above takes my child(ren) for a well visit or for treatment of a medical problem that this person may need to provide consent for my child(ren) to receive medical services the health care provider(s) determines necessary for the care and treatment of my child(ren). I hereby authorize the person(s) listed above to provide consent for the provision of the following medical services to my child(ren) by the medical providers of Primary Care Partners.

☐ **Evaluation** ☐ **Treatment** ☐ **Administration of vaccines**

_____	_____
Name of parent or Legal Guardian	Signature
_____	_____
Relationship to Child(ren)	Date

This authorization shall be valid for each visit that the person(s) identified above takes your child(ren) to a Primary Care Partners Affiliate's office unless you provide written notice to the Primary Care Partners Pracitce listed above that you are revoking authorization.