AUTHORIZATION FOR TREATMENT OF MINORS

Name of Patient: _____ Date of Birth:_____

To: PEARL CITY MEDICAL ASSOCIATES, INC.

In instances when I am unable to accompany my child when he/she needs medical care, I have authorized the following individuals to accompany my child to your office:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Additionally, I authorize you to provide information regarding the treatment of my child to the above-named individuals, so that they are able to relay that information to me. The information disclosed will be limited to that which is relevant to that specific visit.

_____
Print Name of Parent/Legal Guardian

_____ _____
Signature of Parent/Legal Guardian Date