

The Pediatric Lung Center & Allergy

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**Medical Permission Form**

The purpose of this form is to authorize other adults **18 years of age or older** to bring your child to this practice for medical treatment and services. Please complete one form for each child you wish covered by the Medical Permission Form.\*

I, \_\_\_\_\_, give permission for the individual(s) listed below to bring my  
Parent/Guardian's first and last name  
child, \_\_\_\_\_ Child's first and last name \_\_\_\_\_ Child's Date of Birth for office visit(s) and to make  
medical decisions on my behalf for my child. I understand that this individual may be required  
to sign the financial responsibility statement, pay the necessary co-pay and provide proof of  
identification to practice staff before my child is seen.

\_\_\_\_\_  
Authorized Adult's Name (Please print clearly)

\_\_\_\_\_  
Authorized Adult's Name (Please print clearly)

\_\_\_\_\_  
Authorized Adult's Name (Please print clearly)

**PLEASE CHECK ONE:**

Permission is for all future visits my child has at this practice or until I request this authorization be removed.

**OR**

Permission is in effect for the following date(s) or date range: \_\_\_\_\_.

Parent/Guardian Name (PRINT) \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

\*The HIPAA Privacy Rule and our policies and procedures allow us to obtain verbal agreement from you to use and disclose to an individual involved in the patient's care any medical or billing information relevant to that patient's health care.