



Authorization – Non-Parent/Guardian To Accompany Patient 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(ren). **The person bringing your child will need to present a photo identification at time of service.**

This authorization gives the person permission to bring your child(ren) in, speak to the doctor, give authorization for treatment, vaccinations, medication, certain procedures and make general health decisions.

I, _____, give the person(s) listed below permission to bring my child to Pediatric Associates of North Atlanta (PANA) 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 PANA provider.

I also give them authority to make more serious or urgent health care decisions in the event of an emergency.

Parent/Guardian Cell Phone Number: _____

Parent/Guardian Cell Phone Number: _____

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

Name of Person (allowed to bring child)

Relationship

Name of Person (allowed to bring child)

Relationship

Name of Person (allowed to bring child)

Relationship

Name of Person (allowed to bring child)

Relationship

*****This authorization will not expire, please update this form accordingly*****

Signature of Parent/Guardian

Date