# PRIORITY CARE PEDIATRICS

**Alternate Care and Information Sharing Authorization**

It is the policy of our office NOT to provide treatment or other services to minor children unless they are accompanied by a parent or legal guardian. If desired, the parent or legal guardian may authorize others (grandparents, babysitter, etc.) to bring in the patient for care. An older adolescent patient (age 14 or higher) may be permitted to present to the office unaccompanied if permission is granted by the parent or legal guardian. This authorization also grants Priority Care Pediatrics' staff the ability to share patient information with the below listed individuals.

☐ I authorize the following person/people to bring the child listed below for medical treatment including any immunizations or other necessary procedures. I understand that the signature of the listed individual(s) will obligate me to any applicable charges and is a surrogate for my own signature.

☐ I authorize the adolescent child (age 14 or higher) listed above to present for medical treatment if allowed by law. I understand that I will be responsible for any applicable charges for any such visit(s).

☐ I, the patient listed below, hereby give permission to share my health information (excluding information I have identified as confidential, unless required by law or insurance billing) with the individuals listed below.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Expiration Date of Authorization: ☐ None (perpetual) ☐ _____

_____ _____
Patient's Name Patient's Date of Birth

_____ _____
Signature of Patient, Parent, or Legal Guardian Relationship to Patient

_____ _____
Printed Name of Individual Signing Above Today's Date