Laura Bruckner, M.D. Andrew Krasnoff, M.D. Helen Lederer, M.D.
Catherine Marshall, M.D. Sloane Sevran, M.D. Daniel Bruckner, M.D.
Miriam Chan, M.D. Julia Bruckner, D.O. Ofir Mekel, M.D.

Permission to Treat an Unaccompanied Minor

I, _____, give permission to my child _____
(Name of Parent or Guardian) (Name of child age 16-18 years)
to attend his/her illness appointment alone without my presence and authorize treatment for my child in accordance with the office policy of my child's doctor. This includes providing a history of present illness, disclosing protected health information, and responsibility for relaying any diagnosis, treatment plan, or prescription(s) to the parent or legal guardian mentioned above. I agree to be available by phone and to be financially responsible for all co-pay and coinsurance.

This authorization is effective from _____/_____/_____ to _____/_____/_____

Emergency Contact information for Parents/Guardians:

Name:_____ Relationship to Patient:_____

Phone Number: (_____)_____-_____

Comments: _____

_____

Health Insurance Information:

Please have the patient bring the *Insurance Card* (or a copy of) and *Co-Pay* (if necessary) to their visit

Insurance Company_____ Policy Holder_____

Policy ID Number _____ Group Number_____

Effective Date_____ Co-Pay $_____

_____ _____
Parent or Legal Guardian's Signature Date

Please email completed form to info@balboapediatrics.com

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