Laura Bruckner, M.D. Andrew Krasnoff, M.D. Helen Lederer, M.D. Irwin Bruckner, 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 A Minor

I, _____, give permission to _____
(Name of adult to be accompanying child)
to accompany my child _____and authorize treatment for my child in a accordance with the office policy. This includes bringing the child into the office, providing a history of present illness, disclosing protected health information, accompanying consented research study procedures, and witnessing any physical exam completed by the provider. This adult has the responsibility to relay any diagnoses, 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's and coinsurance.

Temporary Guardian Information:

Name:_____ Phone Number: (_____)_____-_____

_____
Address

_____
City State Zip

Relationship to Patient:_____

Parents/Legal Guardians Contact in case of Emergency

Name:_____ Phone Number: (_____)_____-_____

Relationship to Patient:_____

Health Insurance Information:

Insurance Company_____ Policy Holder_____

Policy ID Number _____ Group Number_____

Effective Date_____ Co-Pay $_____

_____ _____
Parent or Legal Guardian's Signature Date

5400 Balboa Blvd Ste326
Encino, CA 91316
818-789-8775