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.**

PERMISSION TO TREAT AN UNACCOMPANIED MINOR

I, _____, give permission to my child _____
(Name of 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-pays and coinsurance. This authorization is effective on:

This authorization is effective from: ___ / ___ / ___ to ___ / ___ / ___

Emergency Contact Information for Parents/Guardians:
Where/how can you be contacted in case of emergency? _____
Phone:_____
Comments:_____

Health Insurance Information:

Insurance Card or copy of & Co-Pay must be accompanied with the patient at time of visit

Insurance Company: _____ Policy Holder: _____

ID Number: _____ Group Number: _____

Effective Date: _____ Co-pay: _____

Parent or Legal Guardian's Signature: _____

Date: ___ / ___ / ___

patientinfo326@yahoo.com