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 A MINOR *(Temporary Consent)*

I, ________________________________, give permission to ___________________________________
(Name of adult to be accompanying child)
to accompany my child _________________________________ and authorize treatment for my child in 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-pays and coinsurance.

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

Emergency Contact Information for Parents/Guardians:

Where/how can you be contacted in case of emergency? _______________________________________

Phone:____

Comments:____

Temporary Guardian Information:

Name:____ Phone: ___________________________

Address: ____

Health Insurance Information:

Insurance Card or copy of & Co-Pay must be accompanied with 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