Arapahoe Park Pediatrics

Authorization To Permit Individuals To Accompany Patients Under 18 To Appointments

Child(ren's) First & Last Name **Date of Birth:**

_____

_____

_____

_____

_____

Choose ONE of the following options:

☐ I, _____, **authorize** the following individuals to accompany my child(ren) to Arapahoe Park Pediatrics for the provision of medical services and to view or discuss my child(ren)'s Protected Medical Health Information. This form does not authorize medical decision making, treatment or immunization consent. Any changes must be made in writing.

Stepfather/Stepmother: _____

Grandparents: _____

Siblings over 18: _____

Other: _____

_____

☐ I, _____, **do not authorize** for anyone other than the child(ren's) father and mother to accompany my child(ren) to Arapahoe Park Pediatrics.

_____

Parent Signature **Date**

EXPIRES 12/31 OF EACH YEAR