



Accompanied by Someone Other Than Parent/Legal Guardian

I, the parent or legal guardian of, _____ give permission for
_____ to bring my child to Salud Pediatrics for
an evaluation and treatment appointment.

Print Name of Parent/Legal Guardian: _____

Signature of Parent or Legal Guardian: _____

Today's Date: _____

I understand that sensitive information can be shared during the visit, including Mental Health, HIV/AIDS, Drug and Alcohol, Sexually Transmitted Disease, Pregnancy, and Birth Control. I understand this form is valid until the patient turns 18 or is otherwise revoked. The revocation will not apply to information that has already been released in response to this authorization. I understand that I have the right to withdraw this authorization at any time by contacting Salud

Pediatrics.