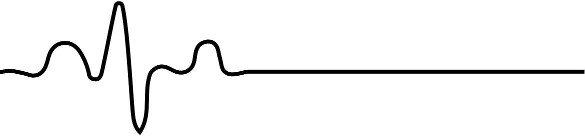
Dr. Mani Khoshnejad, M.D.



Permission to Accompany A Minor

I, ______________________________, give permission to _______________________________
(Name of Parent/Guardian) (Name of adult to be accompanying child)
to accompany my child ____ and authorize
(child's name and DOB)
treatment for my child in accordance with the office policy of MANI K MD PA. This includes bringing the child into the office of MANI K MD PA, 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 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 copays and coinsurance.

This authorization is effective from: _______________ to _______________.
(effective date) (end date)

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

Temporary Guardian Information
Name: ____________________________________ Phone: ______________________________
Address: ____

Parent or Legal Guardian's Name : ____

Parent or Legal Guardian's Signature: ____

Date:____________

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