Accompanying Adult Consent

melmed center

TM

Patient's Name:_____Birthdate: _____

Address:_____City:_____State:_____Zip: _____

I grant permission for the person(s) listed below to be present and participate in my child's appointments and ongoing care including but not limited to telephone, fax & e-mail communication until further written notice.

Name: **Relationship to Child/Children:**

_____

_____

_____

_____

I certify that this request has been made voluntarily and that the given information above is accurate to the best of my knowledge. By my signature below, I further declare that I am the legal guardian of the child listed above and I have the legal authority to grant the above permission. I understand that I have the right to revoke this consent, in writing, at any time, except to the extent that Melmed Center has already taken action in reliance to this consent. This authorization will expire only upon completion of a consent revocation form.

_____ _____

Name of Patient (Please Print) Today's Date

_____ _____

Signature of Patient/Parent/Legal Guardian Relationship to Patient

Please complete and fax to (480) 443-4018

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