



melmed center  
TM

# Accompanying Adult Consent

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:**

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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**

**4848 East Cactus Road, Suite #940 Scottsdale, AZ 85254 (480) 443-0050**

[www.melmedcenter.com](http://www.melmedcenter.com)

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