Authorization to Accompany Minor to Appointment

I authorize the following individual(s) to accompany my child to his/her clinic appointment(s) and further allow Upper Great Lakes Family Health Center to verbally discuss and disclose medical information about my child's visit with:

Print Name: _____

Relationship to Patient: _____

Print Name: _____

Relationship to Patient: _____

This consent is valid for one year from date of signature unless I notify you in writing of my withdrawal.

Patient's Name (printed): _____

Patient's Date of Birth: _____/_____/_____

Parent/Legal Guardian's Name (printed): _____

Parent/Legal Guardian's Signature: _____

Date: _____/_____/_____