



# Children's International<sup>®</sup>

## MEDICAL GROUP

### Non-Guardian Permission Authorization Update Form

☆ PLEASE COMPLETE THE SECTION BELOW IF **YOU GIVE PERMISSION** FOR SOMEONE ELSE OTHER THAN THE LEGAL PARENT/ GUARDIAN TO BRING YOUR CHILD TO ANY FUTURE APPOINTMENTS AND /OR AUTHORIZE THEM TO MAKE ANY DECISIONS NECESSARY TO HAVE YOUR CHILD TREATED PROPERLY BY CHILDREN'S INTERNATIONAL MEDICAL GROUP IN OFFICE OR BY TELEPHONE.

I, \_\_\_\_\_, give my permission to have my child,

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_, brought to the office or discuss medical information by telephone by the following:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office Staff Witness: \_\_\_\_\_ Date: \_\_\_\_\_

☆ IF YOU **DO NOT GIVE PERMISSION** FOR ANYONE ELSE TO BRING YOUR CHILD TO HIS / HER APPOINTMENT OR MAKE MEDICAL DECISIONS, PLEASE COMPLETE THE SECTION BELOW:

I, \_\_\_\_\_, **DO NOT** give anyone permission to have my child,

\_\_\_\_\_, brought in to the office or disclose of medical information to anyone other than myself.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office Staff Witness: \_\_\_\_\_ Date: \_\_\_\_\_