Carithers
PEDIATRIC GROUP

Authorization by Patient, Parent or Legal Representative for Another Person to Bring Child to Physician's Office and Access to Protected Health Information (PHI).

Patient's Name: _____ Date of Birth: _____

I hereby provide permission for the following persons to bring my child to the office and consent to medical treatment including immunizations. If the patient is 18 years of age or older, the patient must sign the form allowing a parent or legal guardian to have access to their PHI.

NAME	RELATIONSHIP	NAME	RELATIONSHIP

For patients 16 years and older ONLY:

Yes____ No____ Patient listed above may present and be treated unaccompanied by an adult.

I understand that when the person(s) identified above takes my child for a well visit treatment or a medical problem that this person may need to provide consent for my child to receive medical services the health care provider(s) determines necessary for the care and treatment of my child. I hereby authorize the person(s) listed above to provide consent for the provision of the following medical services to my child by the medical providers of The Carithers Pediatric Group and sign any necessary waivers on my behalf.

_____ _____

Name of Patient, Parent or Legal Guardian **Signature**

_____ _____

Relationship to Patient **Date**

We will continue to rely on the information on this form unless you request changes. It is your responsibility to immediately notify The Carithers Pediatric Group of a divorce, legal separation, change in custody arrangement, or any other circumstances which may alter this authorization.

To revoke or alter this authorization, please send a written request with a copy of this form to the address below:

The Carithers Pediatric Group
HIPAA Privacy Officer
2121 Park Street, Jacksonville, FL 32204