AUTHORIZATION TO BRING PATIENT TO OFFICE VISIT AND/OR FOR TREATMENT AND COPIES OF RECORDS

Patient Name: _______________________________________ DOB: ________________

I, ______________________________ hereby authorize the following individual(s) to (1) accompany my child, (2) make healthcare decisions and (3) receive copies of his/her medical records in my absence. I give consent to all medical treatment to be rendered. **I understand that this authorization does NOT apply to bringing my child for surgery. I must accompany my child to surgery.**

Name: ____ Relation to patient: ____________________

Name: ____ Relation to patient: ____________________

Name: ____ Relation to patient: ____________________

This authorization also grants to my agent(s) the power to sign for release of information to any third party payers who may be responsible for part or all of the cost of the services provided. This authorization shall remain effective from __________________ to __________________, unless sooner revoked in writing.

____ ______________________________

Signature of Parent/Legal Guardian Date Signed

Thomas M. Andrews, MD ● Peter S. Karemeplis, MD ● Rose Trowbridge, MD ● Kathleen M. Wasylik, MD
P.O. Box 76479 ● St. Petersburg, FL 33734-6479
Office 727-329-5400 ● Fax 727-329-5401

Diplomates, American Board of Otolaryngology
Fellows, American Academy of Pediatrics