PEDIATRIC ASSOCIATES

330 Borthwick Ave
Suite 101
Portsmouth, NH 03801
(603)-436-7171

55 High Street
Suite 102
Hampton, NH 03842
(603)929-3838

CONSENT FOR NON-PARENT TO BRING MINOR CHILD TO APPOINTMENT(S)

NAME OF PATIENT: _____ **DOB:** _____

I authorize the following individual, who is a person over the age of 18, to bring my child to today's appointment and any future appointments. I consent to medical treatment including testing, medications and vaccinations deemed necessary by the medical providers at Pediatric Associates.

_____ _____

(PERSON BRINGING CHILD) **(RELATIONSHIP TO CHILD)**

This consent is valid until revoked in writing by me, the parent/ legal guardian.

_____ _____

Signature of Parent/ Legal Guardian **Printed Name**

_____ _____

Date **Phone # of Parent/ Legal Guardian**

_____

*Additional Permissions *Optional**

1. ____ **FULL ACCESS, NO RESTRICTIONS**. I give the named individual(s) permission to act on my behalf with **NO** limitations. I understand that they may contact any physician or member of the staff at Pediatric Associates of Hampton and Portsmouth to schedule appointments, discuss my healthcare, and access my child's complete medical records.
2. ____ **SCHEDULING APPOINTMENTS AND REFILLING PRESCRIPTION ACCESS ONLY**. I give the named individual(s) permission to contact and speak with any physician or member of the staff at Pediatric Associates of Hampton and Portsmouth to schedule/change an appointment and refilling/picking up prescriptions **ONLY**.
3. ____ **LIMITED ACCESS, SOME RESTRICTIONS**. I give the named individual(s) permission to act on my behalf **WITH** limitations. I understand that they may contact any physician or member of the staff at Pediatric Associates of Hampton and Portsmouth but **NOT** in regards to:

   (list the restrictions you **DO NOT** want us talking about)

   _____

   _____