Greenville Pediatric Services, Inc.
300 Bethesda Drive • Greenville NC 27834 • Tel: 252-752-7141 • Fax: 252-752-0223

PERMISSION TO SEE

Parental Authorization to treat Minor Child when not accompanied by Parent or Guardian

(This authorization is for patients under 18 years of age.)

Patient Name: _____ DOB: _____

We must have consent from a child's parent or guardian before providing medical services when the child is accompanied by someone other than the parent or legal guardian or presents by him or herself. If you feel there may be an occasion when your child will be brought by a relative, sitter, etc., please fill out the following information for us to include with your child's records.

The following person(s) have my consent to authorize medical care for my child and sign any necessary waivers on my behalf.

Name	Relationship

Greenville Pediatric Services, Inc. is allowed to leave voicemails on the telephone numbers provided on the patient demographics sheet regarding patient information:
☐ Yes ☐ No

FOR PATIENT 16 YEARS AND OLDER ONLY:

Patient listed above may present and be treated unaccompanied by an adult. ☐ Yes ☐ No

Parent/Guardian Signature: _____ Date: _____
Witness Signature: _____ Date: _____