



Children's International[®]

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: _____