Infants' and Children's Clinic, P.C.

PERMISSION FOR CHILDREN TO BE SEEN WITH NON-PARENT/GUARDIAN

Patient's Name: _____ Date of Birth: _____

Patient's Name: _____ Date of Birth: _____

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Patient's Name: _____ Date of Birth: _____

Infants' and Children's Clinic, P.C. can no longer treat your child by telephone or in person without a biological parent or guardian present in a non-emergency situation. The only exception to this is if Infants' and Children's Clinic, P.C. has this form on file. You may fill it out in our office and let a member of our personnel witness your signature. Another option is to have this form notarized by a Notary Public and either mail it back to us, 421 W. College Street, Florence, AL 35630, or bring it by our office.

The following people have permission to bring my child to Infants' and Children's Clinic, P.C. to be seen and to call the triage staff of Infants' and Children's Clinic, P.C. to get medical information via the telephone for my child; examples would be grandparents, babysitters, or other family members or friends that might bring the child to the doctor for you or need to call our office regarding your child or make payments for you. They have full authority to act in my behalf should authorization be necessary for testing or treatment (i.e. labs, x-rays, etc.). They may also receive financial information such as the balance on my account. I understand that if any person who is not on this list, calls Infants' and Children's Clinic, P.C. or brings my child to Infants' and Children's Clinic, P.C., except in the case of an emergency, Infants' and Children's Clinic, P.C. will not speak with this person nor see my child in your office. I understand that it is my responsibility to ask for and fill out a new form if any of the following people should be removed. I understand that I can ask that the following people not be given any financial information regarding my account, and I will note this restriction beside their name below if I do not want them to receive this information.

Name	Relationship to patient
_____	_____
_____	_____
_____	_____

_____ _____

Name of Parent/Guardian Date

_____ _____

Signature of Parent/Guardian Witness/Notary

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Effective Date of Notice: September 23, 2013

I acknowledge that I have received Infants' and Children's Clinic, P.C.'s Notice of Privacy Practices.

_____ _____

Signature of Patient/Parent/Legal Guardian Relationship to Patient

_____ _____

Print Parent/Legal Guardian's Name Date

_____ Keyed

_____ Scanned