

CONSENT TO DISCUSS MEDICAL TREATMENT OF A MINOR CHILD

If you are unable to accompany your child to an appointment at one of our offices and would like to give permission for our physicians and staff to discuss your child’s medical treatment with someone else in your absence, please complete the following form.

CONSENT TO DISCUSS FINANCIAL INFORMATION OF A MINOR CHILD

As per our financial policy, unless we have written permission, we will not discuss financial information with anyone other than the person responsible for the patient’s account. If there is anyone who has your permission to discuss this information with our staff, please complete the following form. Patients requiring allergy testing may have out of pocket costs depending on their insurance provider. Please know that the person who accompanies the patient is responsible for the bill or co-pay at the time of the visit.

I, _____, give permission to:

Name *Relationship*

Name *Relationship*

To discuss and provide consent for medical treatment and financial obligations for:

Name: _____ DOB: _____

at Alabama Allergy & Asthma Center. This permission will be valid for:

_____ the duration of enrollment at Alabama Allergy & Asthma Center.

-OR-

_____ from _____ to _____.

Signature

Date Signed