

DeSantis Family Practice, PLLC

Family & Friends Patient Treatment Release Form

Complete this form if there may be times when a friend or other family member may bring your minor child to appointments.

Minor Child's Name

Date of Birth

I, _____, realize there may be times when I may ask or need a family member or friend to bring my minor child to DeSantis Family Practice for healthcare purposes. I authorize the following individuals to bring the above child to be seen and treated by DeSantis Family Practice in my absence:

Name

Relationship

IMPORTANT NOTE: I understand that this authorization does not include health care services which may require a parent or guardian to sign an informed consent. If I am unable to accompany my child for these services, I must provide specific written consent at EACH of these visits to authorize the person assisting in my child's healthcare to sign for these services.

Signature of Parent/Guardian

Date

Printed Name of Parent/Guardian

Witness