DEMERA

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MINOR AUTHORIZATION FORM

At DeMera Allergy Asthma and Immunology Center, we take the privacy of our patients very seriously. With patients that are minors, we recognize and understand that parents, family members and other adults may bring the patient in for their treatment and care. To assure that Personal Health Information (PHI) remains protected, it is critical that we are informed by the minor's parents and/or legal guardians of the adults that are authorized to seek, obtain and be present during treatment for the minor.

1. ____ Relation: _______________________

2. ____ Relation: _______________________

3. ____ Relation: _______________________

By signing below, you hereby authorize the above listed individual(s) to procure and participate in the minor's treatment and consent to DeMera Allergy Asthma and Immunology Center discussing PHI with the individual.

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Signature of Parent / Guardian Date

If the minor will be attending treatment without a parent, guardian or authorized representation, please initial below to authorize and consent to DeMera Allergy Asthma and Immunology Center providing treatment to the minor.

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Initials