



Synergique Healing, PA

Behavioral Health & Functional Medicine

Consent for Non-Parent to Bring Minor Child to Appointment and Release of Medical Records

Name of Patient: _____ Date of Birth: _____

I am the parent or guardian of _____ (legal name of patient) I have the legal right to consent for medical treatment for this child (patient).

I authorize the following individual who is a person of 18 years of age or older and whose relationship to the child is:

(Full Legal Name) (Date of Birth) (Relationship to Patient)

This person above is authorized to bring the child to his or her appointment, to consent to medical treatment which is deemed necessary by the physicians and medical providers at Synergique Healing at the time of appointment. I understand that this delegation includes authorizing the individual above to give and receive medical information/records about the minor necessary to make immediate health care decisions.

This consent is valid until revoked in writing by me, the parent or legal guardian.

Signature: _____ Date: _____

Printed Name: _____

Contact information for parent/guardian: _____