RUDOLPH BOLLING PSYCHIATRY, PC

PERMISSION TO TREAT MINOR BROUGHT TO APPOINTMENT BY NON-GAURDIAN

Patient Name:_______________________________________ DOB __________________

The realities and necessities of work and other life situations occasionally arise that creates a need for relatives or other non-guardians to assist the guardian in transporting the patient to the clinic for treatment and follow-up. As guardian, you must indicate below whether you give permission for your dependent (named above) to receive services and treatment if brought to any appointment by a non-guardian. Please provide your authorization or restrictions for services in the event that the patient presents to the clinic for treatment with a non-guardian.

___**Yes,** as guardian for the above patient, **I give permission for treatment of the patient in my absence**, so long as the treatment is a part of the regularly scheduled regimen of services and treatment provided by Rudolph Bolling Psychiatry, PC, or its physicians or other appropriate representatives. Said permission is given only if the patient is brought for treatment by the persons listed below.

___**Yes**, as guardian for the above patient **I give permission for the listed person(s) to pick up medication(s)/ prescription(s)** written by Rudolph Bolling Psychiatry, PC physician(s) or other appropriate representatives. I understand the listed person may have to sign documentation of receipt of the medications/ prescription.

_______________________________________/______________________________.
Relationship to patient

_______________________________________/______________________________.
Relationship to patient

_______________________________________/______________________________.
Relationship to patient

_______________________________________/______________________________.
Relationship to patient

_______________________________________/______________________________.
Relationship to patient

___**No**, as guardian for the above patient, **I do not give permission for treatment of the patient in my absence.**

___**No**, as guardian for the above patient, **I do not give permission for anyone to pick up medication / prescription other than myself.**

This authorization is valid from the date below until written notification is received from the guardian that this information should change.

______________________________________ ______________________________
Signature of Guardian, if Patient is a Minor Date

______________________________________ ______________________________
Witness Signature Date

Aug 2018