I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the parent/guardian of patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give permission for my minor child to attend his/her medical appointment alone without my presence, and I authorize treatment for my child in accordance with the office policy of Julie Darby-Jett MPAS PA-C LLC.

I understand that office staff will not be able to convey the details of the appointments to me later in the day, rather, it is the responsibility of my child to relay any diagnosis, treatment plan, or prescription back to me as the parent or legal guardian. The office can provide printed patient information at the time of the visit and will provide office notes imported to the patient portal upon request.

The minor will also be responsible for providing a history of present illness and any needed protected health information. I agree to be financially responsible for all charges, copays, and coinsurance incurred in these visits and keep a credit card on file with the office to cover them.

A school excuse/absence note if needed will be provided upon request.

Parent Signature

Printed Name

Date