



glenbrookpediatrics

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Parental Consent for Treatment by Proxy for a Minor Child

(Accompanied by Someone Other Than a Parent or Legal Guardian)

I, the undersigned parent or legal guardian of (Child's Name) _____,
a minor child whose date of birth is _____, by this written
authorization do hereby authorize and indicate my consent and delegation of my authority
for the medical evaluation, diagnosis and treatment of my child listed above to

_____,
(Name of Parental Authorized Individual) (Authorized Individual's relationship to the Patient)

I understand certain patient health information (PHI) may be disclosed at the time of
service and give my consent for disclosure of PHI to: _____

(Name of Parental Authorized Individual)

for the purpose of evaluation and treatment. I understand that this consent is valid until
it is revoked by me or revoked by the physician and that I may revoke this consent at any
time by giving written notice of my desire to do so to the physician.

By signing below, I agree to and hereby authorize the following actions by
_____, until such time as I revoke in writing this

(Name of Parental Authorized Individual)

authorization and consent.

Signature: _____ Date: _____

Relationship to Patient: _____