Allergy Asthma & Immunology Relief of Charlotte
Designation of Personal Representative & Consent For Care and Treatment of a Minor

PATIENT NAME: _____ DATE: _____

I, _____ declare that I am the parent or legal guardian of _____.
(Name of Minor Patient)

I confirm, _____ is a personal representative for all purposes
(Name of person accompanying minor patient)
relating to the minor child's or ward's protected health information. (*See related HIPAA document)

By signing below, I do hereby consent and agree to the following:

- The above mentioned patient to be brought to AAIR for purposes of medical care and treatment by the mentioned representative.
- Paying for co-payments, deductibles, co-insurances, and non-covered balances due at the time of service.
- Providing necessary proof of current insurance to AAIR in order to receive payment for visits, vaccines, and treatments.
- Furnish AAIR a copy of any court order, custody plan, power of attorney, and letters of guardianship or similar documents if requested.
- AAIR is not obligated to examine or treat the child until all documentation it requires has been satisfied regarding authorization for examination and treatment and responsibility for payment.

MINORS AGE 16 OR OLDER:
_____ I authorize the staff of AAIR to treat the above named minor for an office visit and / or shots without my presence or the presence of another accompanying adult in the building.

ALLERGY SHOTS (CONSENT FOR TREATMENT):
_____ In the event that I am unable to **personally** accompany my child/children to AAIR for their immunotherapy, I give my permission for the shots to be administered without my presence and also any treatment that might need to be given due to complications or adverse reactions that could occur from receiving the shots.

My representative will be empowered until AAIR receives written documentation advising otherwise.

_____
Printed Name of Parent / Legal Guardian

_____ _____
Signature of Parent / Legal Guardian ***Date***