I, _____, the parent /legal guardian of _____
(Name of parent/guardian) (Name of Child)

Date of birth _____, hereby authorize _____
(Name of adult accompanying child to office)

to accompany my above-named child, in my absence, to medical and dental office visits at the Erie County Community Health Center, and to consent to the examination and/or treatment of my child during the office visits.

This authorization is effective (Choose one)

- ☐ from _____ to _____
  Date Date
- ☐ effective immediately until revoked by me in writing.

I reserve the right to revoke this authorization at any time by notifying the Erie County Community Health Center in writing.

I understand that my child (under 18 years of age) cannot attend his/her appointment without the accompaniment of the adult listed above.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Health Center Staff Date

_____ _____
Signature of Notary Date