ASSOCIATES IN
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Treatment of Minors

I, _____, hereby grant to Joan M. Griner, MD, Raymond J. Dean, MD, Jeffrey J. Kelly, DO, Stacy Slade PA-C and/or Melissa Sergent, PA-C and such assistants that may be chosen, permission to evaluate, diagnose and treat my child when they arrive at the office.

___ My child will be unaccompanied by a parent or guardian.
___ The minor will be accompanied by _____ (Name/Relation).

Parents/Guardians often find themselves unable to accompany their teenage children to appointments. This form has been prepared for your convenience in the event that you are unable to accompany your child to their appointment.

_____ _____
Patient Name **Patient Date of Birth**

_____ _____
Parent/Guardian Signature **Date**