Family & Friends Patient Treatment Release Form

Patient's Name: ______________________________ **Date of Birth:** ____________________

MRN: ____________________

I, ____________________, realize there may be times when I may ask or need a family member or friend to bring my child to Cornerstone Health Care for healthcare purposes. I authorize the following individuals to bring my child to be seen and treated by Cornerstone Health Care in my absence.

NAME	RELATIONSHIP
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

IMPORTANT NOTE: I understand that this authorization does not include health care services which may require a parent or guardian to sign an informed consent. If I am unable to accompany my child for these services, I must provide specific written consent at EACH of these visits to authorize the person assisting in my child's healthcare to sign for these services.

___________________________________ ____________________

Signature of Parent/Guardian **Date**

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Witness