Juan L. Sotomayor, MD, PC
ALLERGY & ASTHMA
Diagnostic Office

5229 Witz Drive · North Syracuse, New York 13212 · (315) 701-9500 · FAX (315) 701-9555
www.allergyaway.com
Juan Sotomayor, MD · Jill Agne, FNP · Summer Goetz, FNP · Katie Klee, FNP · Anna Salvagno, FNP

Parental Consent and Authorized Adult Designation for Minor Patients

Name of Minor(s)	DOB
_____	_____
_____	_____
_____	_____
_____	_____

I/We, the parent(s) or legal guardian(s) of the minor child(ren) listed above, hereby give permission for the child(ren) to receive medical treatment without my/our presence.

I/We authorize:

_____	_____
Name of Authorized Individual	Relationship to Patient

to make and provide consent for all healthcare decisions on behalf of my child(ren) listed above.

This authorization will remain in effect for one (1) year (365 days) from the date signed below, unless revoked earlier in writing.

I understand and agree that I/We, the parent(s)/legal guardian, remain financially responsible for all charges related to services provided.

By signing, I acknowledge that I have read, fully understanding, and agree with this information.

_____	_____
Printed name of Parent/Legal Guardian	Phone Number
_____	_____
Signature of Parent/Legal Guardian	Date
_____	_____
Address of Parent/Legal Guardian	Witness