PRIMARY CARE
ASSOCIATES OF NJ, LLC
Complete healthcare for the entire family
329 Main Rd, Montville NJ 07045 (973)334-9404 Fax: (973) 334-7615

Date:_____

Patient's Name:_____

Patient's Date of Birth:_____

To Whom It May Concern:

I hereby give permission to Primary Care Associates of N.J., LLC to evaluate and treat the above-mentioned minor in my absence. This treatment may include, but not be limited to: prescribing medications, immunizations, therapeutic injections etc. I am confirming that my parental rights have not been revoked by any court and I have legal custody of this minor and am able to grant this permission.

If minor will be accompanied by someone other than a parent/guardian, please name that person and their relationship to the minor:

Name:_____

Relationship:_____

This permission is granted until it is revoked in writing or until the following date: _____ (If left blank, permission is granted indefinitely)

I hereby give consent for this patient to be given immunizations per current American Academy of Pediatrics/American Medical Association guidelines.

I acknowledge that my insurance company may not be covering the office's cost of certain vaccines and I may be balance-billed up to the office's cost of the vaccine. My insurance company has been informed of this policy.

Signed:_____ Date:_____

Printed Name:_____