

Medical Group

Phone (847) 663-8508
Fax (847) 663-8506

Personal Representative for Minors

I authorize /appoint the following person(s) to accompany my minor child(ren), 17 and under, to appointments at NorthShore University Health System, Department of Pediatric Endocrinology.

Name (Last, First)	Relationship	Child(ren) Name (s)	Date of Birth

I understand that consent is valid until revoked by me and applies to information about me or my children obtained through and all NorthShore Medical Group locations and physicians. I understand that revocation must be presented in writing to this physician's office. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose health information.

Parent/ Guardian Signature: _____ Date: _____

Relationship of person Signing (circle one) Parent Guardian