



PRIMARY CARE
ASSOCIATES OF NJ, LLC
Complete healthcare for the entire family

329 Main Rd, Montville NJ 07045 (973)334-9404

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 I am confirming that my parental rights have not been revoked by any court and I have legal custody of this minor and am able to grant this permission.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: _____