Naoko Matsumoto, M.D., Inc.
松本尚子　小児科
matsumotomd.com

# Authorization – Non-Parent/Guardian to Accompany Patient

I, _____(保護者氏名), give the person(s) listed below permission to bring my child to Naoko Matsumoto, M.D., Inc. and to discuss and share medical information about my child. I further authorize them to see all necessary medical records and make health care decisions of a routine nature as determined at the sole discretion of the provider in Naoko Matsumoto, M.D., Inc.

I also give them authority to make more serious or urgent health care decisions in the event I cannot be reached or where it is of an emergency nature where there is not sufficient time to seek out my specific consent.

(お子さんの氏名)　　(お子さんの誕生日)

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

*(IF ONLY PARENTS ARE ALLOWED TO BRING CHILD IN, PLEASE INDICATE 'NONE')*

_____ _____

Name of Person (allowed to bring child)　　Relationship

お子さんを連れてこられる方の氏名　　続柄

_____ _____

Name of Person (allowed to bring child)　　Relationship

お子さんを連れてこられる方の氏名　　続柄

_____ _____

**Signature (Parent/Guardian)保護者サイン**　　**Date 日付**