

Associates in Family Medicine
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Medical Release Form (Minors)

I, _____, parent/legal guardian of _____, whose date of birth is ____ / ____ / ____ .

hereby authorize the individual(s) listed below to bring my child in for an appointment with Dr. Michelle Hamidi and associates. This authorization entitles these individuals to act on my behalf in making any necessary medical decisions in my absence, including but not limited to: signing for immunizations and authorizing treatment recommended by a medical provider.

Name	Address	Telephone	Preferred Language

I understand that only those whose name is not listed above will NOT, under any circumstances, be allowed to bring my child in for any reason. I further understand that any changes to this list MUST be made in advance and in writing.

Parent/Legal Guardian Signature

Date