



BROWN

Health Services
Box 1928
Providence, RI 02912
401-863-3953

To return form, student must
login to
<https://patientportal.brown.edu>
and upload.

AUTHORIZATION FOR MEDICAL CARE AND TREATMENT OF A MINOR
To be completed by parent / guardian

NOTE: WITHOUT A SIGNED AUTHORIZATION BY PARENT/GUARDIAN, THE DEPARTMENTS OF HEALTH AND WELLNESS CANNOT TREAT STUDENT

Student Name _____

Date of Birth _____

Banner ID # B0 _____

"I, _____, being the parent or legal guardian of

_____, hereby specifically designate the departments of Brown University Health and Wellness and/or any authorized member of its staff, as the Primary Care Provider (PCP), to examine and treat for all health and medical problems, injuries and emergency treatment that may occur.

I understand that for continuity of care, Brown University Health and Wellness would have access to emergency room records and hospital records at local hospitals, if my student were to need those services.

Brown University Health and Wellness will keep all medical information confidential as per the privacy policy which I have reviewed on the Health Services website at <http://brown.edu/go/privacynotice> or the Counseling & Psychological website at <http://brown.edu/go/CAPStreatmentapproach>.

I understand that this authorization is effective until the minor mentioned above reaches his/her 18th birthday.

Parent/ Guardian Signature _____

Address _____

Phone number _____

Date _____