



804 English Road; Suite 100  
Rocky Mount, NC 27804  
252-443-3133  
[www.rmfmcc.com](http://www.rmfmcc.com)

**Parental Consent Form**

I, \_\_\_\_\_, do hereby state that in my absence,  
\_\_\_\_\_ may bring my minor child, \_\_\_\_\_  
to any/all office visits at Family Medical Center of Rocky Mount. I understand that the  
named temporary guardian will be expected to present identification at each visit and stay  
in the room at all times during the visit. By signing this statement, I also agree to give the  
named temporary guardian access to my child's medical and financial information, and  
permission to make medical decisions as needed.

This will be effective as of the signature date and will expire: \_\_\_\_\_.

Patient's Name: \_\_\_\_\_  
Patient's Address: \_\_\_\_\_  
Patient's Account Number: \_\_\_\_\_  
Parent's Identification Number: \_\_\_\_\_

Parent's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

This document may be revoked by the parent/legal guardian at any time by providing Family Medical Center documentation in writing.  
Temporary guardian must be 18 years of age or older.