HEALTHVISIT HEALTHCARE AUTHORIZATION

Name of the parent /Guardian:

_____

Address of the parent/Guardian: _____

Phone No_____ Email ID _____

Name of the loved-one to whom you give HealthVisit authority to visit:

_____

Address of the person(s) to whom you give HealthVisit authority to visit:

_____

Name of the Loved-One_____Date of Birth_____

What are the reasons to take this step? _____

_____
_____
_____
_____

Date on this authorization: _____

Date of the Visit(s): _____

Parent/ Guardian Signature _____Authorizing the HealthVisit Observation Report.

Date _____

**The HealthVisit Representative merely documents what is observed during the authorized visit.*