Third-Party Authorization

This form is used for the following purposes:

- A family member or friend that is not listed in the patient's chart frequently partakes in the care of your child.
- Known absence and temporary transfer of care to a family member of friend not listed in the patient's chart.

A separate form must be filled out for each individual child.

I/We .....

Name:
Relationship to the patient: ○ Mother ○ Father ○ Other; please specify: _____
Primary Phone:

and

Name:
Relationship to the patient: ○ Mother ○ Father ○ Other; please specify: _____
Primary Phone:

Appoint the following person:
Name: Relation to the Patient: Address:

Primary Phone:

...as my/our proxy decision maker for consent to medical care (including vaccine administration, medication administration, and minor clinic procedures for my/our child.

PATIENT INFORMATION
Patient ID:
Patient Name:
Date of Birth:

Please choose one of the following options:
○ Valid for one year starting today,
○ Valid for six month starting on ____/_____/_____
○ Only from ___/____/_____ to ___/____/_____

I have read this document, and I understand and agree with my requirements and my proxy. By singing this document, I attest that the information above is true and complete, and I have the legal authority to delegate consent for care for the patient named above. I hereby authorize Every Child Pediatrics to treat my child. This document will remain a part of the medical record. If I decided not to sign this authorization, I understand Every Child Pediatrics cannot treat my child without my presence.

Name:

Signature:_____
Name:

Signature: