genesis
pediatric medicine

Medical Authorization Form- Consent (by Proxy) for Non-urgent Pediatric Care

I grant _____ _____
Name of Proxy Address

who is my child's _____ as my proxy decision maker for consenting to non-
Relationship of Proxy to Patient

urgent medical care for my child _____.
Name of Patient

I have the legal right to delegate such consent to the proxy decision maker, who is an adult and legally and medically competent to exercise the authority so delegated. Be advised that protected patient health information may be shared with the proxy to facilitate informed decision making.

Limitations

Identify any limitations on the kind of medical services for which this consent is given. If none, state "None". _____

_____

Identify any limitations on the time frame for which this consent by proxy is given. If none, state "None". _____

_____

Contact Information

If the nature of the medical care is not routine, please try to contact me regarding the health of my child at the following telephone numbers. If you are unable for any reason to contact me, you may rely on the proxy decision maker for consent.

Parent's Name _____

Daytime phone _____

Evening phone _____

Cell phone _____

IN WITNESS HEREOF, the undersigned has executed this instrument as of the _____ day of _____, 20____.

Parent or legal guardian _____

Proxy Decision Maker _____

Driver's license number of Proxy decision maker _____