GENERAL PARENTAL DELEGATION FORM OF A MINOR

I, _____, the parent and/or guardian of the minor, (Parent/Guardian Name)

_____, with the date of birth _____, hereby authorize the (Patient Name) (Patient DOB)

following person(s) to bring said minor in for appointments and make medical decisions regarding their care. **Authorized Person(s)** (use additional form for more than 3 people)

First and Last Name	Relationship to Patient	Phone Number
First and Last Name	Relationship to Patient	Phone Number
First and Last Name	Relationship to Patient	Phone Number

I authorize the person(s) listed above to make the following medical decisions (check all that apply):

☐ Wellness Exam	☐ Sick Visit	☐ Immunization Consent
☐ Procedures	☐ Medication Consent	☐ Other _____

For the following time period (choose one):

☐ As of this date _____/_____/_____ with no end date.

☐ Specific Time Period as indicated _____ through _____/_____/____ at which time this authorization will be automatically be null and void.

Consent

I understand that this authorization will act as my consent for the above-named minor to receive medical care as checked above. I understand that personal health information may be released to said authorized person(s) during any visit to Intown Pediatrics, LLC. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Intown Pediatrics, LLC. I understand that the revocation will not apply to any medical care given through the receive date of revocation.

Parent/Guardian Name		Relationship to Patient
Parent/Guardian Signature	Date	Phone Number