Pediatric Associates of Hampden County

CONSENT BY PROXY FOR NONURGENT PEDIATRIC CARE FORM

For families who are ongoing patients of Pediatric Associates of Hampden County:

I (we) appoint _____, who is my (our) child(ren)'s

_____ as my (our) proxy decision maker for consenting to non-urgent medical care for my (our) child(ren) listed below. I (we) 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.

Child's Name: _____DOB:_____
Child's Name: _____DOB:_____
Child's Name: _____DOB:_____

LIMITATIONS Specify any limitations on the kinds of medical services for which this authorization is given**.**
If none, state none:

_____

_____

Specify the time frame for which this authorization is given. (If no time frame given this form will expire in one year of signature and date):

☐ NONE ☐ 1 YEAR ☐ OTHER DATE_____

CONTACT INFORMATION

If the nature of the medical care is not routine, please try to contact me (us) regarding the health care of my (our) child at the following telephone number(s).

Parent's Name:_____
Daytime Phone:_____
Evening Phone:_____
Cell Phone:_____

Parent's Name:_____
Daytime Phone:_____
Evening Phone:_____
Cell Phone:_____

IN WITNESS WHEREOF, the undersigned has executed this notice as of the _____day of_____, 20____.

_____ Parent or Legal Guardian Name (print)

_____ Parent or Legal Guardian Name (Print)

_____ Parent or Legal Guardian Signature

_____ Parent or Legal Guardian Signature

_____ Proxy Decision Maker Signature Date

_____ Driver's License Number of Proxy Decision Maker