THE CENTER FOR PEDIATRIC & ADOLESCENT MEDICINE PROFESSIONAL ASSOCIATION

AUTHORIZATION FOR CARE

www.cpam.us ~ 125-1 Greentree Drive, Dover, DE 19904 ~ Phone: (302)-678-8333

PATIENT FULL NAME	DATE OF BIRTH	FEMALE	MALE
		☐	☐

I hereby state that I am the parent/ guardian of the above named child and I am legally responsible for making any and all decisions regarding their medical care. The caregiver(s) named below are my proxy decision makers and are authorized to bring my child to The Center for Pediatric & Adolescent Medicine, P.A. for medical appointments/treatment and make medical decisions in my absence. Those named below are adults and legally and medically competent to exercise this authority as delegated and detailed below

I further authorize The Center for Pediatric & Adolescent Medicine, P.A. to triage or discuss with those designated below, either in person or by phone, my child's symptoms and/or medical condition in order to assist and advise the caregiver concerning the immediate treatment options for my symptomatic child. This includes releasing relevant protected health information.

Caregiver Full Name (Print)	Relationship to Child

If the nature of the medical care is not routine, please attempt to contact me at the following phone number: _____

If for any reason you are unable to contact me, you may rely on the caregiver for consent. I further authorize the above named caregiver(s) to obtain any medical records/forms from the practice office on my behalf. I agree to be financially responsible for all services rendered in my absence. This authorization shall be in effect until revoked, in writing, by me.

IMPORTANT NOTICE: Caregivers must bring proper photo identification to the office.

THIS FORM MUST BE SIGNED IN THE PRESENCE OF THE NOTARY.

_____ _____

Parent or Legal Guardian Signature Date

_____ _____

Print Name of Parent or Legal Guardian Date

_____

Type of Identification/ ID#

_____ _____

Notary of Public Date