CONSENT BY PROXY FOR TREATMENT OF A MINOR

I appoint 1)_____
(Name) (proxy's relationship to children)

2)_____
(Name) (proxy's relationship to children)

as my proxy decision maker for consenting to medical care for my children listed below. This consent includes, but is not limited to evaluation, care, and treatment from providers working at Bainbridge Pediatrics. I understand such services may include examination, medical and minor surgical treatment, x-ray, laboratory, immunizations and other medical services performed or prescribed. I have the legal right to delegate such consent to the proxy decision maker, who is an adult over the age of eighteen (18) and is 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.

Name:_____ DOB:_____

Name:_____ DOB:_____

Name:_____ DOB:_____

Name:_____ DOB:_____

Name:_____ DOB:_____

LIMITATIONS

Identify any limitations on the kinds of medical services for which this consent by proxy is given. If none, state "none".

_____

_____

_____

This consent will remain in effect for one year from the date of signature unless otherwise stated below.
This consent is to remain in effect until _____ , 20_____.

_____
Parent or Legal Guardian Signature Date

_____
Parent or Legal Guardian Name

_____
Proxy Decision Maker (1) Signature Date

_____
Proxy Decision Maker (1) Name

Proxy Contact Number _____

_____
Proxy Decision Maker (2) Signature Date

_____
Proxy Decision Maker (2) Name

Proxy Contact Number _____