Designee Authorization Form

I, the parent/legal guardian of the below named child:

______________________________ ______________

Print Child's Name *DOB*

authorize and consent to the examination and/or treatment of my child during office and facility visits by the physicians and clinical staff of Pediatric Wizards. In addition, I give permission for the following person(s) to bring my child to Pediatric Wizards in my absence and to act in my behalf in authorizing medical care and treatment. In the event of emergency or other illness, I understand that the physicians and staff of Pediatric Wizards will deliver any medical care deemed necessary regardless of the accompanying adult. **Unless we are notified in writing,** Pediatric Wizards will assume that a child's biological and/or legal parents are both legal guardians who have access to treatment options and medical information for that child.

I designate the following people to bring my child in on my behalf, to obtain treatment, and to discuss my child's health care with Pediatric Wizards:

Name: ______________________________ Relationship: ______________

Name: ______________________________ Relationship: ______________

This authorization shall be in effect from ________ *to* ________ *or* ☐ *until further notice*

______________________________ ______________

Parent/Guardian Printed Name *Date*

____

Parent/Guardian Signature