coastal pediatric group

AUTHORIZATION TO PROVIDE MEDICAL CARE

I, _____, being the parent/guardian of _____, authorize the following list of individuals to consent for treatment of my above mentioned child. I understand that by providing the following information about the individuals, I am allowing Coastal Pediatric Group to verify to the best of their ability the identity of the individual. If at any time I wish to remove a name from this list of persons authorized to consent for medical care of my child, I may do so by requesting a new form, filling it out, and signing again. I also understand that if there is any necessary treatment that requires a major decision be made, Coastal Pediatric Group will make every effort to contact me first. However, if no contact can be made with a parent, and I have authorized the individual to consent for treatment, the individuals listed below have my permission to make decisions for my child's medical care. This authorization will be indefinite and will only expire if I fill out a new form. All individuals listed below will be required to provide at least one form of identification that must include a photograph as well as the information provided below for verification purposes. I understand that this is being done to protect my child's well-being.

The following individuals are authorized by me to consent for treatment:

Name of Individual	Relationship to Patient	Date of Birth
Name of Individual	Relationship to Patient	Date of Birth
Name of Individual	Relationship to Patient	Date of Birth
Name of Individual	Relationship to Patient	Date of Birth
Name of Individual	Relationship to Patient	Date of Birth
Name of Individual	Relationship to Patient	Date of Birth

Signature of Parent	**Name of Parent**	**Date**

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