GENERAL PARENTAL DELEGATION FORM OF A MINOR

I, _____ , the parent and/or guardian of the minor,
(Parent/Guardian Name)

_____, with the date of birth _____, hereby authorize the
(Patient Name) (Patient DOB)

following person(s) to bring said minor in for appointments and make medical decisions regarding their care.
Authorized Person(s) (use additional form for more than 3 people)

_____
First and Last Name Relationship to Patient Phone Number

_____
First and Last Name Relationship to Patient Phone Number

_____
First and Last Name Relationship to Patient Phone Number

I authorize the person(s) listed above to make the following medical decisions (check all that apply):

☐ Well Visit appointment ☐ Sick Visit appointment ☐ Immunization Consent

☐ Procedures ☐ Medication Consent ☐ Other _____

For the following time period (choose one):

☐ As of this date _____/_____/_____ with no end date.

☐ Specific Time Period as indicated _____/_____/_____ through _____/_____/_____ at which time this authorization will be automatically be null and void.

Consent

I understand that this authorization will act as my consent for the above named minor to receive medical care as checked above. I understand that personal health information may be released to said authorized person(s) during any visit to Leawood Pediatrics, LLC. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Leawood Pediatrics, LLC. I understand that the revocation will not apply to any medical care given through the receive date of revocation.

_____
Parent/Guardian Name Relationship to Patient

_____
Parent/Guardian Signature Date Phone Number