Mark 9 Pediatrics℠
Healthcare for Babies to Teens

DELEGATED ADULT IN LIEU OF PARENT OR GUARDIAN

Today's Date_____ **Date of Office Visit**_____

Reason for OfficeVisit

_____

I am the parent or guardian of

_____ _____
Name of Minor/Child Date of Birth (DOB)

I authorize _____(Authorized Party or Person) to act as my delegate for the visit listed above. This person is authorized to make health care decisions for my minor child during this office visit appointment. I understand that this authorization is only valid for the visit listed above and will not be accepted once the visit is completed. Health care decisions include consenting to assessments and treatment such as in-house testing, developmental screening, immunizations, and medications given in the office. The authorization does not extend beyond the walls of Mark9 Pediatrics and it is the understanding of this practice that I will continue to be the primary decision maker for my minor child.

I will be contacted for consent if the delegate is unable, unwilling or uncomfortable with making health care decisions for my minor child. If I am unavailable and my delegate cannot consent for reasons stated above, I understand that any routine care such as routine immunizations and health maintenance assessments will not be performed and only urgent or acute care will be provided for my child based on the medical expertise of Dr. Moemeka and the clinical staff at Mark9 Pediatrics.

Print Name _____

Signature_____ Date_____

Relationship to minor child_____