



I hereby authorize the following individuals to make medical decisions for my child in the event of my absence.

**(Persons other than parents or guardians)**

**\*Parents, please keep in mind, emergencies do come up and unless a person is listed on your child's chart, per HIPAA guidelines, they will NOT be able to have your child treated without documentation from you that they have authorization to have child seen without you being present. Please list ANYONE who may EVER need to bring your child in, in the event that you can not! Persons living outside of the state IS acceptable! Thank You!**

**Examples:** (Grandparents, Older Siblings, Aunt/Uncles, Child Care Providers)

Name of Person	Relationship to Child

\_\_\_\_\_  
Patient Name (Please print)

\_\_\_\_\_  
Printed Name of Parent or Guardian

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Effective Date