

Pediatric & Adolescent Center of NW Houston, PA

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CONSENT BY PROXY FOR NON-URGENT PEDIATRIC CARE (Underage Teen)

(For families who are ongoing patients of Pediatric & Adolescent Center of NW Houston)

I _____, give permission for my
(Name of Parent/Legal Guardian)

underage child _____,
(Patient Name) (Date of Birth)

to seek treatment from Pediatric & Adolescent Center of NW Houston PA independently. I have the legal right to provide this consent.

LIMITATIONS

Identify any limitations on the kinds of medical services for which this consent by proxy is given. If none, state "none."

Identify any limitations on the time frame for which this consent by proxy is given. If none, state "none."

CONTACT INFORMATION

If the nature of the medical care is not routine, please try to contact me regarding the health care of my children at the following telephone number(s). If you are unable for any reason to contact me, you may rely on the proxy decision maker for consent.

Parent's Name

Parent's Name

Daytime phone

Daytime phone

Evening phone

Evening phone

Cell phone

Cell phone

Signature of Parent/Legal Guardian

Date