Authorized Representative Form

Commonwealth Pediatrics
commonwealthpediatrics.com
781-451-0072 | *fax* 781-435-0792

I am the parent/legal guardian of the child(ren) listed below, and authorize the following representative(s) to consent to all necessary & appropriate medical care for said children on my behalf. This includes but is not limited to diagnostic examinations, immunizations, anesthetic, and hospital care to be rendered to the minor at a recognized medical facility under the general or special supervision of a licensed physician or nurse practitioner.

I understand it is the policy of Commonwealth Pediatrics that a parent or legal guardian attend every well care visit. I understand that copays will still be due at the time of service.

I understand that the provider may not contact me directly, instead relying on the adult(s) below to explain the visit to me.

I understand that if an injury or illness is determined to be life threatening, the provider will make every effort to contact me. If I am unreachable, the authorized representatives below may consent to emergency care for my child.

I understand this form will remain in effect for 1 year, will need to be renewed annually, and may be revoked at any time by my written request.

Parent/Legal guardian information

Last name: _____

First name: _____

Date of birth: _____

Last name: _____

First name: _____

Date of birth: _____

Patient information

Last name: _____

First name: _____

Date of birth: _____

Last name: _____

First name: _____

Date of birth: _____

Last name: _____

First name: _____

Date of birth: _____

Authorized representative information

Last name: _____

First name: _____

Date of birth: _____

Cell phone: _____

Relation to patient(s): _____

Last name: _____

First name: _____

Date of birth: _____

Cell phone: _____

Relation to patient(s): _____

Parent/Legal guardian signature

_____

Today's date: _____