Associates in PEDIATRIC CARE Hampton, LLC

The purpose of this form is to authorize another individual other than yourself (i.e., Mother, Father or Legal Guardian), to bring in your child for medical appointments & make health care decisions them.

Name of Patient _____ Date of Birth _____ Chart #_____

I, _____, hereby appoint the authorized agent listed below to be allowed to bring my child or children to their medical appointment(s) and to make all healthcare decisions for them concerning their medical treatment, including required or recommended vaccinations. I accept financial responsibility for the actions/decisions of my authorized agent and agree to pay all costs of care rendered by Associates in Pediatric Care Hampton, LLC or its employees that were authorized by my agent. I hereby release and hold harmless the Children's Clinic, Ltd. and its employees from any and all liability for any action or omission taken at the directions of my authorized agent.

___ If this box is checked, I also allow the practice to discuss my financial account regarding this child with my agent.

Authorized Agent Name:

_____

Relationship to Patient: _____ Phone #: _____

I affirm that there are no court orders in effect that would prohibit me from exercising or conferring the rights and responsibilities that I wish to confer upon this individual. I understand that, if the affidavit is amended or revoked, I must provide the amended affidavit or revocation to all parties to whom I have provided the affidavit.

Parental Rights:

- I have the right to revoke this authorization at any time.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- This form does not authorize the agent broad rights to access the minor child's medical record.

This authorization will remain in effect until revoked by the parent or when the patient becomes 18 years of age.

_____ Date _____

Signature of Parent

CM 11/2023