AUTHORIZATION OF DELEGATE --- Adult

Patient Name:_____ DOB: _____

□ I authorize the following delegate(s) to act on my behalf regarding my healthcare.
□ I decline. Do not discuss my care with anyone other than myself, except as mandated by HIPAA.*

Signed:_____ Date: _____

I wish to delegate the person(s) below in the following matters:
□ Schedule, confirm and cancel appointments
□ Speak to MKPAC staff regarding my care and treatment
□ Speak to MKPAC staff regarding my bill
□ Pick up my prescriptions, medical records, or medical equipment from MKPAC
□ Other: _____

Person(s) authorized: (Please note, authorized persons must be 18 or older and present photo ID at each visit)

Name: _____
Relationship to patient:_____ Phone #: _____
Effective until (mm/dd/yyyy)_____or until revoked in writing, whichever occurs first.

Name: _____
Relationship to patient:_____ Phone #: _____
Effective until (mm/dd/yyyy)_____or until revoked in writing, whichever occurs first.

Name: _____
Relationship to patient:_____ Phone #: _____
Effective until (mm/dd/yyyy)_____or until revoked in writing, whichever occurs first.

Please circle your PREFERRED METHOD OF COMMUNICATION: Home Phone/Cell Phone/Text/Email

PERMISSION TO LEAVE DETAILED MESSAGE

I authorize practitioners and staff of MKPAC to leave detailed voice, text or email message(s) when contacting me via one or more of the preferred methods of communication listed above.

Effective until _____(mm/dd/yyyy) or until revoked in writing, whichever occurs first.

□ I decline. Except appointment reminder messages, do not leave detailed voice messages.

* Subject to My Kid's Pediatrics and Adolescent Care ("MKPAC") privacy policy.