AUTHORIZATION OF DELEGATE - Minor

Patient's Legal Name	Date of Birth
Patient's Legal Name	Date of Birth
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We encourage you to accompany your child to appointments whenever possible but recognize that you may not always ne available when your child is in need of medical attention. This form allows you to delegate others to act on your behalf.

☐ I decline to delegate. Do not discuss my child's care with anyone other than those listed as custodians except as mandated by HIPAA. Subject to My Kid's pediatrics and Adolescent Care ("MKPAC") privacy policy.
☐ I revoke all previous authorizations of delegate as of the date signed below.
☐ I wish to delegate one or more representatives in the following manner (check all that apply)

Name of delegate	Relationship	Phone #
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I wish to delegate the person above the following matter(s):

☐ Schedule, confirm, and cancel appointments for my child/children.
☐ Speak to MKPAC staff regarding my child/children's care and treatment.
☐ Accompany my child/children to visits at MKPAC and in general to act on my behalf during the visit to authorize treatment, including but not limited to vaccinations and/or procedures.
☐ Speak to MKPAC staff regarding my child/children's bill.
☐ Pick up my child/children's prescriptions, medical records, or medical equipment from MKPAC.
☐ Other: _____

Authorized delegate must be at least 18 years old and present a photo ID at each visit

My Signature acknowledges that I, (name)_____, am the legally authorized representative of the patient(s) listed above, and as such I have the authority to delegate others to act on my behalf regarding my child's healthcare.
This authorization is valid as of the signature date and is effective until __/__/____ or until revoked in writing, whichever occurs first.

_____ Signature of legally authorized representative

_____ Relationship to patient (please print)

_____ Date