HOWARD COUNTY PEDIATRICS, LLC

CONSENT FOR NON-PARENT TO BRING MINOR CHILD TO APPOINTMENT

Name of Patient:_____ **Date Of Birth:**_____

I am the parent or guardian of _____ . I have the legal right to consent for medical treatment for this child (**patient**).

I authorize the following individual, who is a person over 18 years of age and whose relationship to the child is:

_____ _____

(Person Bringing Child to Appointment) **(Relationship to Child)**

to bring the child to his or her medical appointment, and to consent to medical care which is deemed necessary by the physicians and medical providers at Howard County Pediatrics, LLC at the time of the appointment. I understand that this delegation includes receiving necessary health information about the minor to make immediate health care decisions.

This consent is valid until revoked in writing by me, the parent or legal guardian.

_____ _____

Signature of Parent or Guardian **Printed Name** **Date**

Contact Info of Person Bringing Child to Appointment:

- **Name:**
- **Phone Number:**
- **Email & Mailing Address:**