Pediatric & Adolescent Center of NW Houston, PA

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CONSENT BY PROXY FOR NON-URGENT PEDIATRIC CARE (Underage Teen)

(For families who are ongoing patients of Pediatric & Adolescent Center of NW Houston)

I _____, give permission for my
(Name of Parent/Legal Guardian)

underage child _____ _____,
(Patient Name) (Date of Birth)

to seek treatment from Pediatric & Adolescent Center of NW Houston PA independently. I have the legal right to provide this consent.

LIMITATIONS

Identify any limitations on the kinds of medical services for which this consent by proxy is given. If none, state "none."

_____

_____

_____

Identify any limitations on the time frame for which this consent by proxy is given. If none, state "none."

_____

_____

CONTACT INFORMATION

If the nature of the medical care is not routine, please try to contact me regarding the health care of my children at the following telephone number(s). If you are unable for any reason to contact me, you may rely on the proxy decision maker for consent.

_____	_____
Parent's Name	Parent's Name
_____	_____
Daytime phone	Daytime phone
_____	_____
Evening phone	Evening phone
_____	_____
Cell phone	Cell phone

_____ _____
Signature of Parent/Legal Guardian Date