JOSEPH P. ADDABBO FAMILY HEALTH CENTER, INC.
CONSENT BY PROXY FOR NON-URGENT CARE OF MINOR PATIENTS

I _____ authorize the Joseph P. Addabbo P
PRINT NAME OF LEGAL GUARDIAN/PARENT

Family Health Center and its personnel to deliver medical services to my child,

_____ _____.
CHILD'S NAME CHILD'S DATE OF BIRTH

Furthermore, in my absence I authorize the following people to bring my minor child in for treatment and act as proxy decision maker to consent to non-urgent medical care. I have the legal right to delegate such consent to the proxy decision makers who are adults and mentally competent to exercise the authority so delegated. I am aware that protected patient health information may be shared with the proxy to facilitate informed decision making.

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

LIMITATIONS:
Identify any limitations on the kinds of medical services for which this authorization is given. If none, state "none".
_____
_____
_____

CONTACT INFORMATION:

Mother's Name:_____	Father's Name:_____
Best Contact Phone:_____	Best Contact Phone:_____
Evening Phone:_____	Evening Phone:_____
Cellphone:_____	Cellphone:_____

_____ _____ _____
SIGNATURE OF LEGAL GUARDIAN/PARENT RELATIONSHIP TO CHILD DATE

_____ _____ _____
SIGNATURE OF LEGAL GUARDIAN/PARENT RELATIONSHIP TO CHILD DATE

_____ _____
SIGNATURE OF WITNESS DATE

Revised: 10/04/2016 (P: general access/policies & procedures/patient care)