Parent/Legal Guardian Authorization for Medical Care for Dependent

Name of Dependent: _____

Date of Birth: _____

I (we) _____
(name)

(and) _____
(name)

authorize the following adult _____

to act in my/our behalf in seeking and authorizing medical care and in all respects act as the personal representative for health care for the above named dependent in my/our absence.

Please check the appropriate box below:

☐ This authorization is to remain in effect until _____
(date)

OR

☐ This authorization is to remain in effect until revoke in writing by me/us

Parent/Legal Guardian Signature: _____

Date: _____