

United American Indian Involvement, Inc.

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Consent by Proxy For Non-urgent Pediatric Care Form

I (we) appoint, the following individual/individuals as my (our) proxy decision maker,

Name: _____

Relationship to child: _____

Name: _____

Relationship to child: _____

The above named individual/individuals may consent to non-urgent medical care for my (our) child listed below.

Child's name: _____ DOB: _____

I (we) have the legal right to delegate such consent to the proxy decision maker, who is an adult and is legally and medically competent to exercise the authority so delegated. I (we) consent to the sharing of protected patient health information with the proxy to facilitate medical decision making.

Limitations on the kinds of medical services for which the above designed proxy may consent: (If none, state "none")

This consent is good for 1 year and may be revoked at any time.

Parent/guardian (print): _____

Daytime phone: _____ Cell phone: _____

Signature: _____ Date: _____

Parent/guardian (print): _____

Daytime phone: _____ Cell phone: _____

Signature: _____ Date: _____

Witness: _____ Date: _____