St. Augustine Pediatric Associates

HEALTH CARE PROXY FOR MEDICAL TREATMENT

Name of Patient: _____ DOB: _____

Name of Patient: _____ DOB: _____

Name of Patient: _____ DOB: _____

Name of Patient: _____ DOB: _____

Name of Patient: _____ DOB: _____

Name of Parent or Legal Guardian: _____

Address: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Mobile/Cell Phone: ( ) _____

Name of Person with Health Care Proxy: _____

Home: ( ) _____ Work Phone: ( ) _____

Mobile/Cell Phone: ( ) _____

This authorization is to confirm that I am the parent and/or legal guardian of the above named child/children and that I am authorizing the person named above with my healthcare proxy in order to make all decisions relating to the medical care recommended for my above named child/children. I therefore release St. Augustine Pediatric Associates from any and all liability related to the reliance on the consent and approval regarding treatment rendered to my child/children recommended and/or performed at the request of the healthcare proxy named above. This authorization and release shall remain valid and in effect until written notice of revocation is received.

Dated this _____ day of _____, 20____.

Signature of Parent and/or Legal Guardian

Sworn to and subscribed before me this ___ day of _____, 20_____.

_____

Notary Public, State of Florida

My Commission expires on: _____

My Commission # is: _____