Lowcountry Pediatrics

AUTHORIZATION FOR ALTERNATE CAREGIVERS

Patient Name _____ Date of Birth _____

Please list any caregivers that you authorize to obtain medical care for your child in your absence.

Please provide the front desk with a copy of any legal documentation describing guardianship or financial responsibility if other than biological parent(s). Please note that both biological parents are legally entitled to receive medical information on a minor unless otherwise ruled by the Judicial System and documentation is presented to Lowcountry Pediatrics. This authorization shall be enforced until revoked by the patient, parent, legal guardian, or personal representative (as defined by HIPAA).

With my permission I hereby authorize the following individuals to consent to all medical care and attention which is deemed necessary and appropriate by a healthcare provider at Lowcountry Pediatrics for this child. This consent includes, but in not limited to Emergency services, lab tests, procedures and immunizations. The listed individuals are given authority to discuss and change appointments, financial or insurance details, and clinical information including labs.

Alternate Caregiver Name	Relationship to Child	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient/Parent/Legal Guardian Signature: _____

Printed Name: _____ Date: _____