Blueberry Pediatrics

Healthcare Proxy Consent Form

I, _____ (Parent or Legal Guardian), hereby authorize Blueberry Pediatrics and it's physicians to release information concerning my child's care and provide medical care and treatment in my absence to the following individuals:

Name: _____ Relationship to patient: _____
Name: _____ Relationship to patient: _____
Name: _____ Relationship to patient: _____
Name: _____ Relationship to patient: _____

This authorization applies to the following patient(s):

Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____

I understand that for the safety and security of my child, only adults listed on this form will be permitted to consent to care. If at any time I wish to revoke this authorization, I will notify Blueberry Pediatrics in writing via email sent to info@blueberrypediatrics.com.

Parent/Guardian Signature:

Print Name: _____ **Today's Date:** _____