Ocoee Pediatrics

Delegation Of Consent

Name of Patient _____ DOB: _____

I hereby authorize the following individual(s) make medical decisions if I am not available.

Name of Person	Phone Number	Relationship to Patient
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

The above individuals may consent to any medical care and treatment that is deemed necessary and appropriate by a licensed healthcare provider at Ocoee Pediatrics. This consent includes, but is not limited to, medical and surgical procedures, as well an elective and emergency care. This delegation of consent will remain in effect until a new delegation of consent is complete.

Patient Signature: _____ Date: _____