REIS PEDIATRICS
KAILUA PROFESSIONAL CENTER I | 30 AULIKE ST, SUITE 500, KAILUA, HI 96734 | 808.263.8822
WWW.REISPEDIATRICS.COM

MEDICAL DECISION AUTHORIZATION

Patient name: (include all children) Date(s) of birth:

☐ **CHECK HERE IF ONLY LEGAL GUARDIAN, MOTHER OR FATHER ARE AUTHORIZED.**

By signing this medical decision authorization form, I am stating that I am the parent and/or guardian for the above named patients and am legally responsible for making any and all decisions regarding their medical care. I also authorize the following people to bring my children in to the office of Reis Pediatrics for medical care and to make medical decisions in my absence (please note any exceptions):

Name: Relation to child/children: Exceptions to decision making:

I also authorize the people I have listed to pick up any medical records/forms on my behalf.

ID CARD WILL BE REQUIRED.

Name of parent/legal guardian

Signature Date