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Delegation of Consent Form

Today's Date: _____/_____/_____

Patient Name _____

Date of Birth _____/_____/_____

Parent/Legal Guardian's Printed name _____

I authorize the following persons to accompany my child to seek medical care and to make decisions in relation to medical care and advice rendered at Rainbow Pediatrics of Houston, PLLC and/or its employees in my absence. I understand that I am responsible for payment of all charges that result from care provided by Rainbow Pediatrics of Houston, PLLC including amounts not covered by my health plan.

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Note: Authorized persons will be required to bring a valid photo ID and the patient's insurance card to every visit.

This authorization will remain in effect until revoked in writing by the parent or legal guardian.

By signing below, I acknowledge that I have read, understand, and agree to this Delegation of Consent.

Signed: _____ Print Name: _____

Date: ____/_____/_____ Relationship to Patient: _____