STEEPLECHASE
PEDIATRIC CENTER

NCMC Office
21216 Northwest Fwy, Ste. 470
Cypress, TX 77429
Tel: 281-469-2838
Fax: 281-469-9314

Cypress Skinner Office
13611 Skinner Rd, Ste 145
Cypress, TX 77429
Tel: 281-304-7337
Fax: 281-469-9314

Cypress Springs Office
7626 Fry Road, Ste 500, Cypress, TX 77433
Tel: 281-469-3305
Fax: 281-469-9314

Katy Office
22762 Westheimer Pkwy., Ste. 560,
Katy, TX 77450
Tel: 281-921-0590
Fax: 281-469-9314

Fulshear Office
11605 S Fry Rd., Ste. 108
Fulshear, TX 77441
Tel: 281-469-4340
Fax: 281-239-2104

Authorization for Non-Parent to Consent to Care

I am the legal guardian/ parent of:

_____ _____
Patient's Name **Date of Birth**

_____ _____
Patient's Name **Date of Birth**

_____ _____
Patient's Name **Date of Birth**

_____ _____
Patient's Name **Date of Birth**

I authorize the following persons to seek medical care for the above listed child(ren):

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

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

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

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

This authorization permits the above-named persons to consent for:

_____ **Medical care** _____ **Labs** _____ **Vaccinations**

_____ **Antibiotic injections** _____ **Prescriptions**

This authorization will remain in force until revoked in writing by me. I hereby attest that I have the legal authority to delegate my authority to consent for care, and that no legal agreement prevents me from delegating authority.

_____ _____
Parent/Guardian Signature **Date**

_____ _____
Printed Name **Relationship to patient**