



SUNRISE PEDIATRICS

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Delegation of Consent

Name of Patient: _____

Patient's Date of Birth: _____

I hereby authorize (when I am unavailable, to give consent to the following individual(s)):

_____	_____
Name of person	Relationship to Patient
_____	_____
Name of person	Relationship to Patient
_____	_____
Name of person	Relationship to Patient

To consent to any and all medical care and attention for this patient/child which is deemed necessary and appropriate by a healthcare provider licensed in the state of Texas. This consent includes, but not limited to, medical and surgical intervention and elective as well as emergency care. This delegation shall be valid until I withdraw delegation of consent.

Signature of Parent/Guardian/Patient (If 18 years or older)

Relationship to Patient

Date

Witness

Translator/Reader (if applicable)