SUNRISE PEDIATRICS

11920 Westheimer Rd, Suite E
Houston, TX 77077
Phone Number: (281) 679-6165
FAX: (281)670-5790

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)