Williamsville Pediatric Center

Designation of Another Person to Consent for Treatment

I, (parent/legal guardian) ________________________, cannot accompany my child, (child's name, DOB) ______________________________, to Williamsville Pediatric Center.   Therefore, I give permission to (person's name) ____________________ as follows (check one):

- ☐ I give permission for this person to seek treatment (including any type of procedure, medication administration, vaccination, test, mental health care, etc) and provide consent for such treatment if attempts to contact me are unsuccessful.
- ☐ I give permission for this person to seek treatment (including any type of procedure, medication administration, vaccination, test, mental health care, etc) and provide consent for such treatment <u>without</u> having to contact me.

Expiration of Permission (check one):

- ☐ This for will remain in effect until revoked by filling out the form on page 2.
- ☐ This form is valid only during the following timeframe:
    - Effective date: __________ / Expiration date: __________

X ________________________ Date: __________
Signature of parent or legal guardian

X ________________________ Date: __________
Signature of witness 18 yrs or older

Address ____________________
____

Phone ______________

Williamsville Pediatric Center

Notice to Revoke "Designation of Another Person to Consent for Treatment"

I, (parent/legal guardian) ________________________, am legally responsible for child, (child's name, DOB). Please immediately revoke prior permission for (person's name) ____________________ to consent for treatment of my child.

X ________________________ Date: ___________
Signature of parent or legal guardian

X ________________________ Date: ___________
Signature of witness 18 years or older

Address ____________________
____

Phone _______________