483 East County Line Rd.
Hatboro, PA 19040

Consent for Non Parent/Guardian to Accompany Patient to Appointment and Access Patient Information

Patient Legal Name: ______________________________ **Date of Birth:** ___/___/____

Patient Chosen Name: ______________________________

I, ______________________________ hereby authorize Hatboro Pediatrics, P.C. to allow the below individual (s), who is 18 years of age or older, to assist in the care and treatment of my child in my absence:

Designated Adult (18 or over)

Name: ______________________________ Relationship to Patient: ______________

Designated Adult (18 or over)

Name: ______________________________ Relationship to Patient: ______________

Designated Adult (18 or over)

Name: ______________________________ Relationship to Patient: ______________

Designated Adult (18 or over)

Name: ______________________________ Relationship to Patient: ______________

By authorizing the above individual (s), I hereby agree to abide by all the financial responsibility associated with the care and treatment of my child. I will be responsible to pay Hatboro Pediatrics, PC.

I agree to the following Terms and Conditions:

- The proxy requestor must be the parent or legal guardian of the pediatric patient.
- The proxy requestor must complete and sign this form.
- Each proxy requestor must submit one form per child.
- Proxy access can be terminated only by written request.

Should another adult be designated in the future, I will submit an updated version of this form.

Parent/Guardian Signature: ______________________________ **Todays Date:** ___/___/____