



# Alaska Center for Pediatrics

BIRTH THROUGH ADOLESCENT CARE

## ***OTHER AUTHORIZED ADULT CONSENT***

If I am unable to attend my child(ren)'s appointment, I give consent for the following adult(s) to attend my child's appointment, to sign for medical care and make treatment decisions for my child(ren). I understand that when I designate another person to authorize treatment decisions for my child(ren), ACP may offer protected health information relative to that decision to the designated person.

I, \_\_\_\_\_, give consent for the following adult(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

to sign for medical care and treatment of my child(ren):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This consent form expires on \_\_\_\_\_ unless revoked by me in writing before that date.

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Signature

Relationship

Date

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Witness

Date

**1200 Airport Heights Drive, Suite 140  
Anchorage, Alaska 99508**

**Tel: 907.777.1800 Fax: 907.278.2066**