CAMELBACK PEDIATRICS, P.C.

4350 East Camelback Road, Suite G100
Phoenix, Arizona 85018
Phone (602) 840-3120
Fax (602) 840-3237
www.camelbackpediatrics.com

Milton K. Scharff, MD
Susan J. Apley, MD
Kristin A. Struble, MD
Forrest T. Gnagi, MD
Cheryl L. Marshall, PA-C
Crystal M Ostermeyer, PA-C

CONSENT BY PROXY FOR NON-URGENT PEDIATRIC CARE

It may be more convenient to have prior authorization in place so that medical care may be delivered directly to minors if a parent or legal guardian cannot be present prior to treatment. Please review the following authorization for treatment and complete if you wish to authorize such treatment for your minor child(ren) in advance.

***All proxy representatives must be at least 18 years of age and present a valid photo ID at the time of check-in.**

Child's name:		Date of Birth:	
Child's name:		Date of Birth:	
Child's name:		Date of Birth:	
Child's name:		Date of Birth:	
Child's name:		Date of Birth:	
Child's name:		Date of Birth:	

I, _____ have the legal right to delegate such consent to the proxy decision maker, who is an adult* and legally and medically competent to exercise the authority so delegated. I am aware that protected patient health information may be shared with the proxy to facilitate informed decision making.

Appointed Proxy Name:	Date of Birth:	Relationship to Patient:	
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LIMITATIONS:
Identify any limitations on the kinds of medical services for which this proxy is given. If none, state "none."
_____
_____
Identify any limitations on the time frame for which this proxy is given. If none, state "none."
_____
_____

IN WITNESS WHEREOF, the undersigned have executed this instrument:

_____
Parent or Legal Guardian Signature

_____
Printed Name of Parent or Legal Guardian Date

Witnessed and I.D. verified by_____