Authorization to Consent for Treatment

Patient First Name:

Patient Last Name:

DOB:

I am the parent and/or legal guardian of the above minor patient and am providing signed consent to the administration of due vaccines and/or vaccine records for the child. I am authorizing the following person/persons, aged 18 years and older, to sign all required forms on my behalf if I do not attend the appointment. I understand that the named person/persons below will need to provide their photo ID at the time of service.

Named Person to Consent and Relationship to Patient: _____

Named Person to Consent and Relationship to Patient: _____

This authorization expires 1 year from the date of signature listed below.

Parent/Legal Guardian Name and Relationship to Patient: _____

Parent/Legal Guardian Signature and Date: _____

Party Receiving Request (HPH Employee):