HIRSCH
PEDIATRICS

AUTHORIZATION FOR HEALTH CARE SERVICES

I give authorization to the following individuals listed below to make medical decisions for my child(ren) in my absence (i.e. grandparent, relative, neighbor, babysitter):

_____ _____

_____ _____

_____ _____

_____ _____

These individuals are authorized to take any and all lawful acts, deeds, matters, and things in any way connected with my child's health care. Such authorization includes, but is not limited to, the giving, refusing, or withdrawing consent to provide professional services on behalf of my child(ren)

This authorization shall remain in full force and effect until one or both of us are available by telephone, in person or otherwise to make health care decisions for my child(ren).

Date	Signature of Legal Guardian (or patient)	Print name of Legal Guardian (or patient)
	Patient(s) Name(s)	**parent** Relationship to Patient