CapitalCare Medical Group

A division of Community Care Physicians, P.C.

APPOINTMENT OF TEMPORARY DELEGATE FOR TREATMENT OF MINOR

CHILD'S NAME: DATE OF BIRTH: ACCOUNT #:

_____ _____ _____

I/We being the parent(s) or legal guardian of the above-named minor do hereby appoint

_____ _____
Name Phone number

_____
Relationship to Child

to act on my/our behalf in authorizing medical, dental or surgical care and hospitalization in my/our absence for the above-named minor.

PARENT/GUARDIAN SIGNATURE: _____

PARENT/GUARDIAN (PRINTED): _____

Relationship to Child: _____
(please specify parent, legal guardian or other legal authority)

Street Address: _____

City: _____State: _____ZipCode: _____

Home Phone: _____Work Phone: _____

Date: _____ Expiration Date: _____

(If no date is stated, this authorization expires one year from the date it was signed.)

Witness Signature: _____