MEDICAL AUTHORIZATION FOR ALTERNATE CAREGIVER (ACG)

Permission for Medical Treatment

In my absence, I _____ *(name of parent or legal guardian)* authorize

_____ (*name of authorized adult)* as "Alternate Care Giver" (ACG) for my

child _____ (*child's name and date of birth*) to seek and authorize treatment for my child (listed above) from Capital Area Pediatrics, Inc. for the following types of service (check all that apply):

___ All Services listed below - ALL
___ Urgent Sick Care (may include laboratory testing or injection of medication) - US
___ Emergency Care (may include hospitalization, and items designated above) - EC
___ Office Surgery (i.e. wart removal, incision and drainage, wound repair and local anesthesia) - OS
___ Preventive Care and Immunizations – PC/IMM

This authorization is effective as of: _____ and will expire on _____, unless I withdraw authorization with written notice prior to expiration date.

ACG must have a picture ID that matches the following:

ID Description: _____ (i.e. VA driver's license) ID Number: _____

ACG relationship to Child: _____ (stepparent, nanny, grandparent)

- I understand that a parent/guardian is required to attend the first visit with the child.
- I understand that if the provider feels this non-parent/guardian does not supply sufficient information during a visit, the provider may discontinue the visit, and reschedule the appointment when a parent/guardian is able to attend.

Parent/Guardian Contact Information *(in case the provider needs to speak directly with you)*

Parent/Guardian Name:_____ **Phone**: _____

Relationship to Patient:_____

Parent or Legal Guardian's Signature: _____Date: _____