Authorization And Consent Of Parent(S) Or Legal Guardian(S) To Authorize Relatives/Friends to bring the child for office visits at Oscar Pediatrics

1) I do hereby state that I have legal custody of the aforementioned Minor.

Minor Details

Full Legal Name: …….

Home Address: ……

……..

Date of Birth: ……..

Gender: Female ……. Male …….

2) I grant my authorization and consent for person(s) mentioned below

Person # 1 ……. Cell # ……..

Person # 2 ……..…… Cell # ……..

(hereafter "Designated Adult") to transport the minor for office visits, to attend and to issue consent for purposes related to office visits ranging from well visits, sick visits, vaccinations, and or any other treatment / procedures offered by Oscar Pediatrics ("medical facility").

3) I agree to assume financial responsibility for all expenses of such care.

4) It is understood that this authorization is given in advance of any such medical treatment, and is given to provide authority and power on the part of the Designated Adult in the exercise of his or her best judgment upon the advice of any such medical personnel.

5) I understand that it is my responsibility to reach out to the medical office to update the names of authorized persons in case of any changes.

Parent/Legal Guardian Signature: ……..

Print Name: ……. Date: ……

Cell: ……... Email: ……