

## MEDICAL DECISION AUTHORIZATION

Patient name:

Date of birth:

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By signing this medical decision authorization form, I am stating that I am the parent and/or guardian for the above named patients and am legally responsible for making any and all decisions regarding their medical care. I also authorize the following people to bring my children in to the office of Reis Pediatrics for medical care and to make medical decisions in my absence (please note any exceptions):

Name:

Relation to child:

Exceptions to decision making:

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I also authorize the people I have listed to pick up any medical records/forms on my behalf.

ID CARD WILL BE REQUIRED.

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Name of parent/legal guardian

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Signature

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Date