# Clackamas & Oregon Pediatrics: AUTHORIZATION OF DELEGATE - Minor

**Patient Name:** ______________________________________ **DOB:** ____________________ ***EMR:***

**We encourage you to accompany your child to appointments whenever possible, but recognize that you may not always be available when your child is in need of medical attention. This form allows you to delegate others to act on your behalf.**

My signature acknowledges that I, (name)______________________________________________, am the legally authorized representative of the patient/child listed above, and as such I have authority to delegate others to act on my behalf regarding my child's healthcare.

This authorization is valid as of the signature date and is effective until (mm/dd/yyyy) _________________ or until revoked in writing, whichever occurs first.

______________________________________________ ______________________________ _________________

Signature of legally authorized representative    Relationship to patient (please print)    Date

☐ **I decline to delegate.** Do not discuss my child's care with anyone except as mandated by HIPAA. *Subject to Clackamas/Oregon Pediatrics privacy policy.*

☐ **I revoke all previous authorizations of delegate** as of the date signed above.

☐ **I wish to delegate** one or more representatives in the following manner (check all that apply):

Name of Delegate: __________________________________________________ Phone #: ____________________________

Relationship to Patient: ____________________________ *Delegate must be 18 years of age or older and present photo ID at each visit.*

- ◯ To schedule, confirm, and cancel appointments for my child.
- ◯ To speak to Clackamas & Oregon Pediatrics staff regarding my child's care and treatment.
- ◯ To accompany my child to visits at CPC/OP and in general to act on my behalf during the visit to authorize treatment, including but not limited to vaccinations and/or procedures.
- ◯ To speak to CPC/OP staff regarding my child's bill.
- ◯ To pick up my child's prescriptions, medical records, or medical equipment from CPC/OP.
- ◯ Other: ____________________________________________________________________________

Name of Delegate: __________________________________________________ Phone #: ____________________________

Relationship to Patient: ____________________________ *Delegate must be 18 years of age or older and present photo ID at each visit.*

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- ◯ To speak to CPC/OP staff regarding my child's bill.
- ◯ To pick up my child's prescriptions, medical records, or medical equipment from CPC/OP.
- ◯ Other: ____________________________________________________________________________

**Please list your <u>PREFERRED METHOD OF COMMUNICATION</u>:**

1. ______________________________________________
   Home Phone/Cell Phone/Text/Email

2. ______________________________________________
   Home Phone/Cell Phone/Text/Email

**PERMISSION TO LEAVE DETAILED MESSAGE**

I authorize practitioners and staff of CPC/OP to leave detailed voice, text or email message(s) when contacting me via one or more of the preferred methods of communication listed above.

Effective until (mm/dd/yyyy) _________________ or until revoked in writing, whichever occurs first.

☐ **I decline.** Except appointment reminder messages, do not leave detailed voice messages.