# APPOINTMENT OF AGENT
## (Authorization for Medical Care)

I, the undersigned, hereby appoint the individual(s) named below who are of lawful age, as my agent(s) and representative for the purpose of authorizing and consenting to medical care and treatment of my child(ren) named below by the physicians and staff of **Holy Family Medical Associates, L.L.C**.., for any preventative care, illness, or injury that may occur while he/she is in the care or custody of said agent and I the undersigned am not present to give such consent. This authorization is not intended to allow the named agent to have access to medical information regarding said child or to control the distribution of medical information except as is necessary for furtherance of medical care.

**Information About Agent(s):**

| Name(s): | Relationship to Patient: |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

| Child(ren): | D.O.B. |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
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| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

This consent is to be in force and effect from this date until revoked in writing by the undersigned.

_____ _____

Signature of Patient/Parent/ Guardian Date