Delegation of Consent

Name of Patient ______________________________

Patient's Date of Birth ______________________________

I hereby authorize (when I am unavailable to give consent) to the following individual(s):

Name of person	Relationship to patient
______________	______________
______________	______________
______________	______________
______________	______________

to consent to any and all medical care and attention for this patient/child which is deemed necessary and appropriate by a healthcare provider licensed in the state of Texas. This consent includes, but is not limited to, medical and surgical intervention and elective as well as emergency care. This delegation shall be valid until I withdraw delegation of consent.

____
Signature of Parent/Guardian/Patient (if 18 years or older)

____
Relationship to Patient

____
Date

____
Witness

____
Translator/Reader (if applicable)

Thank you for choosing OakBend Medical Group.