Authorization of Delegate (AOD)

PATIENT LABEL HERE

Today's Date: ________/________/________

Patient Name: ____ Patient DOB: ________/________/________

This form allows you to delegate others to act on behalf of the above-named patient regarding their healthcare with Clackamas & Oregon Pediatrics. Your signature below acknowledges that you are the patient, or a legally authorized parent/guardian of the person listed above. As such, you have the authority to delegate others to act on the patient's behalf regarding their healthcare needs. This authorization is valid as of the signature date and will remain in effect until the date indicated below or it is revoked in writing.

☐ **TEMPORARY Authorization:** This signed authorization is ONLY valid until _______/________/_______.

☐ **PERMANENT Authorization:** This signed authorization is valid until revoked in writing.

☐ **REVOKED Authorization:** I revoke all previous authorizations as of the signature date below.

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/or cancel appointments.
- ◯ To speak with staff regarding care and treatment.
- ◯ To speak with staff regarding any billing related needs.
- ◯ To pick up prescriptions, medical records, or medical equipment.
- ◯ **Minor Patients only:** To accompany my child to visits and to act on my behalf during the visit to authorize treatment, including but not limited to vaccinations and/or procedures.
- ◯ Other: ____

Name of Delegate: ____ Phone #: (_________)______________________

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- ◯ Other: ____

X____ ____________________________ _____/_____/_____

Signature of Parent / Legal Guardian **Relationship to Patient** **Date Signed**