**CONSENT FOR NON-PARENT TO BRING MINOR CHILD/DISABLED ADULT TO APPOINTMENT**

Name of Patient: ______________________________ Date of Birth: ______________________

I am the parent or guardian of ______________________________ (legal name of patient).
I have the legal right to consent for medical treatment for this child/disabled adult (patient).

I authorize the following individual, who is a person over 19 years of age and whose relationship to the patient is:

______________________________________________ ____________________________________
(Person bringing patient to appointment) (Relationship to patient)

to bring the patient to his or her medical appointment, and to consent to medical care which is deemed necessary by the physicians and medical providers at Lincoln Surgical Group PC at the time of the appointment. I understand that this delegation includes receiving health information about the minor/disabled adult necessary to make health care decisions including surgical procedures.

**This consent is valid until revoked in writing by me, the parent or legal guardian.**

_____________________________ _____________________________ ______________________
Signature of Parent or Guardian Printed Name Date

Contact information for parent/guardian: __________________________________________
Phone Number