Neeta R. Bhardwaj, M.D., P.A.

# Authorization for Medical Treatment/Delegation of Consent

_____ _____

Name of Patient Patient's Date of Birth

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

1. Name: _____
Last First Middle

Relationship to Patient: _____ Phone Number: _____

2. Name: _____
Last First Middle

Relationship to Patient: _____ Phone Number: _____

3. Name: _____
Last First Middle

Relationship to Patient: _____ Phone Number: _____

4. Name: _____
Last First Middle

Relationship to Patient: _____ Phone Number: _____

The above listed individual(s) are able to consent to any and all medical care and attention for this 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, immunizations, and elective as well emergency care. This delegation shall be valid until I withdraw delegation of consent.

Printed name of parent/guardian/patient (if 18 or older):_____

Signature of parent/guardian/patient (if 18 or older):_____

Relationship to the patient: _____

Date:_____

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