Anna Schwartz, M.D. - Amy Leonard, M.D. (Phone: 631-698-0600 – Fax: 631-698-2212)

Delegation of Authority to Consent

In my absence, I hereby authorize_____

(Designee over 18 Years of Age)

Residing at _____

to give oral and written consent to have emergency medical or dental care of treatment performed at _____hospital, and/or, in the office od Drs. Schwartz and Leonard, of

_____

(Name of Patient under 18 Years of Age)

Who is presently residing at_____
with the same force and effect as If I had given such consent myself.

The Authorization is intended to remain in full force and effect until terminated by me in writing. I understand that by signing this authorization, I take responsibility for providing true, accurate and current health insurance information within 7 days of treatment. When failure to do so results in denial of payment for late filing, responsibility for payment will revert to me.

Date: _____

Signature: _____ _____

(Relationship to patient under 18 years)

Print Name: _____ Phone: _____

Witness: _____ Print Name: _____

Leave this form on file at the offices of Drs. Schwartz and Leonard, for office services.

Create a second form to be carried by a relative or responsible adult in the event of need of emergency services for the above named minor.

NOTE: Children and young people under 18 can be treated in the Emergency Unit when parents or guardians are not available.

• Parent should be present for first appointment.

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