

**PALM BEACH PEDIATRICS, P.A**  
**3933 NORTH HAVERHILL ROAD, SUITE 116, WEST PALM BEACH, FL 33417**  
**12955 PALMS WEST DRIVE, SUITE 100, LOXAHATCHEE, FL 33470**  
**8200 S. JOG ROAD, SUITE 101. BOYNTON BEACH, FL 33472**

**Consent by Proxy for Non-Urgent Pediatric Care/Release of Information**

This form gives Palm Beach Pediatrics, P.A. authorization to treat the below patient and release information to persons other than the immediate parent/guardian.

Name of Child: \_\_\_\_\_

Date of Birth/Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Contact Number: \_\_\_\_\_

I, \_\_\_\_\_ hereby authorize Palm Beach Pediatrics, P.A. to allow the below individuals to assist in the care and treatment of my child in my absence:

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

By authorizing the above individuals, I hereby agree to abide by all the financial responsibility associated with the care and treatment of my child. I will be responsible to pay Palm Beach Pediatrics for the following:

1. Any co-payments as set by my insurance carrier
2. Any unsatisfied deductible or termination of coverage
3. Any amount my insurance carrier deems my responsibility
4. Any amount considered non-covered by my insurance carrier

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Printed Name