SHAH and ASSOCIATES FAMILY PRACTICE

POWER OF CONSENT FORM

I, _____ (Name of Parent or Legal Guardian),

designate _____
(Name of Person Bringing Child for Treatment)

to consent to necessary treatment for the following child:

_____
(Patient's Name)

_____
(Date of Birth)

The power that I confer is specifically limited to health care decision-making and verification of patient demographic and insurance information and it may be exercised only by the person named above.

The person named above may consent to the examinations and treatment for my child with Shah and Associates Family Practice.

I confer the power to consent freely and knowingly in order to provide for the child and not as a result of pressure, threats or payments by any person or agency. **This document shall remain in effect, as noted above, or until it is revoked by my written notification to my child's health and insurance providers, and the person named above.**

In witness whereof, I have signed my name to this consent authorization, on this

_____ day of _____, 2013.

_____ _____
(Printed Name) (Signature Of Parent/Legal Guardian)

_____ _____
(Printed Name) (Signature of Person, Power of Consent is given)

_____
(Witness Signature)