



Dr. K. Mathew Warnock
18220 State Hwy 249, Suite 330
Houston, TX 77070
Ph: (281) 807-4380 Fax: (281) 807-6305

Authorization for Non-Parent Consent to Care

I am the legal guardian/parent of:

Patient's Name

Date of Birth

I authorize the following persons to seek medical care for the above listed child(ren):

Name: _____

Relationship to patient: _____

Name: _____

Relationship to patient: _____

Name: _____

Relationship to patient: _____

Name: _____

Relationship to patient: _____

Name: _____

Relationship to patient: _____

This authorization will remain in force until revoked in writing by me. I hereby attest that I have the legal authority to delegate my authority to consent for care, and that no legal agreement prevents me from delegating authority.

Parent/Guardian Signature

Date

Printed Name