



**REDWOOD**  
**PEDIATRICS**  
An Affiliate of Children's Mercy

Alternate Caregiver Authorization Form

Minors require the presence of a parent or legal guardian to obtain treatment from Redwood Pediatrics. By signing below, I grant authority for the following individuals to also obtain medical care for my child at Redwood Pediatrics. By extension, information in the medical chart may be shared with the below listed individuals. I will remain financially responsible for the care that is generated from visits accompanied by the following caregivers.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Parent/Legal Guardian Name: \_\_\_\_\_

Person(s) I hereby extend authority to obtain medical care for above child:

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Expiration Date of Authorization (choose one):

\_\_\_/\_\_\_/\_\_\_ **OR** None (perpetual)

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_