

**Amherst Pediatric Associates**  
**Authorization Form for Substitute Caretaker**

I \_\_\_\_\_ (Please circle) parent / custodial guardian of the following children (please print names / D.O.B.)

- |          |              |
|----------|--------------|
| 1. _____ | D.O.B. _____ |
| 2. _____ | _____        |
| 3. _____ | _____        |
| 4. _____ | _____        |
| 5. _____ | _____        |

do hereby authorize the following individual(s) to act in my stead in accompanying the above named child(ren) (patient(s)) of Amherst Pediatric Associates (APA), to an office visit or immunization visit at their offices at 19 or 25 Hopkins Road, Williamsville, N.Y. 14221.

Name(s) of Substitute Caretaker(s), e.g. grandparent, relatives, nanny etc.

- | (please print) | (relationship to patient) |
|----------------|---------------------------|
| 1. _____       | _____                     |
| 2. _____       | _____                     |
| 3. _____       | _____                     |
| 4. _____       | _____                     |
| 5. _____       | _____                     |

I further recognize the doctors and staff of APA to discuss my child(ren)'s Protected Health Information (PHI) with the substitute caretaker(s), and to provide to them diagnosis, treatment plans, prescriptions, and requisitions for testing.

This authorization is effective until the 18<sup>th</sup> birthday of an individual child or until revoked or changed by me.

Name (print) \_\_\_\_\_  
Signature \_\_\_\_\_  
Date \_\_\_\_\_