PROXY CONSENT TO TREAT MINORS FORM

Medical practice requires a parent or legal guardian to be present at child healthcare appointments, but realize this may not be possible. This form may be used to provide written consent to allow an adult other than a parent to serve as a proxy decision maker for routine medical care and appointments.

For some families, it may be more convenient to have prior authorization in place that allows medical care to be delivered to a child if a parent or legal guardian cannot be present to provide consent. If you would like to appoint such a "proxy decision maker", please complete the form below.

Child's name:_____ Date of birth: _____

Authorization:

I hereby appoint as a **"proxy decision maker"**: _____ _____
NAME RELATIONSHIP

to consent to and authorize routine health care treatment and services for my child listed below. Routine medical care and interventions may include, but are not limited to: medical evaluation, physical exam, x-rays, lab work, allergy testing, pulmonary function testing. This practice also may give limited immunizations, allergy shots, intramuscular/intravenous medications with the consent of the proxy decision maker.

Limitations:

Identify any specific kinds of medical services you **do not** authorize (if no limitations, state "none").

_____

_____

Parent/Legal guardian contact information for questions regarding treatment:

Parent's/Legal Guardian's Name: _ Phone: _

Alternative number:_____

Parent's/Legal Guardian's Name: _ Phone: _

Alternative number:_____

I hereby authorize the proxy decision maker (named above) permission to:
1) consent to and authorize routine medical care as may be deemed necessary or advisable in the diagnosis and treatment of the child listed above, and
2) to receive protected health information directly relevant to, and for the purposes of, this care or payment related to this care.
I also agree to accept financial responsibility for all care and services delivered under this authorization. This authorization is valid until the above child's 18th birthday, unless withdrawn in writing to this practice.

_____ _____
Signature of Parent or Legal Guardian (Only one parent's signature is required.) Date

_____ _____
Signature of Witness Date

****Please send current medications or at least a list to each visit.**