DELEGATION OF AUTHORITY CONSENT TO TREAT MINORS FORM

This delegation of authority to consent to treat a minor child allows the authorized individual below to make decisions about the medical care and services received by the minor child(ren) at _____ (name of clinic and hereafter clinic). If you would like to delegate authority to another individual capable of making health care decisions for a minor child, please review and complete the following form.

AUTHORIZATION:

I hereby authorize

_____
FULL NAME, DOB, Address, Telephone Number

as the delegated decision maker to consent to and authorize medical care and services as may be deemed necessary or advisable in the care, diagnosis and treatment of the minor child(ren) listed below and to receive protected health information for purposes of his or her involvement in their care. (*More than one child may be listed*)

Child's Name:_____ DOB:_____

Child's Name:_____ DOB:_____

Child's Name:_____ DOB:_____

Child's Name:_____ DOB:_____

LIMITATIONS:
Identify any specific limitations on the medical services for which this authorization is given (*If no limitations, please initial the statement below.)* The limitations will be applied to all children listed.

_____ No limitation on the kinds of medical services. (Please initial)

I hereby indemnify and hold harmless the clinic and all their employees, agents, attorneys, directors, insurers, affiliates, direct or indirect subsidiaries, related corporations, successors, heirs and assigns from any and all liability for acting in reliance on this delegation authorization. The individual authorized to make health care decisions (listed above) is permitted to make decisions or consent to the medical care and/or services for my child(ren) in my absence. I also agree to accept financial responsibility for all care and services delivered pursuant to this delegation authorization. This delegation authorization is valid for one year (1) following the date signed below unless withdrawn in writing to the clinic. The delegate named above may not delegate the authority conveyed to another representative. In the event of a divorce, the signature of the child(ren)'s custodial parent is required.

(Signature of appointed Health Care Representative, appointed Legal Guardian, Parent or Adult Sibling)

_____
___ Health Care Representative ___ Legal Guardian ___ Parent ___ In Loco Parentis ___ Adult Sibling

Date: _____

Witness: _____

Date: _____