St.Vincent | ASCENSION

PROXY CONSENT TO TREAT MINOR FORM

Purpose: This form will be used to allow an adult other than a parent to serve as a proxy decision maker for non-urgent routine medical care at _____ ("Provider").

For some families, it may be more convenient to have prior authorization in place that allows certain routine medical care to be delivered directly to minors under the care of a proxy decision maker if a parent or legal guardian cannot be present. Please review and complete the following form authorizing a proxy decision maker to be involved in the care of a minor child.

AUTHORIZATION

I (we) appoint _____ _____
Name Relationship

as proxy decision maker for health care decisions involving our child listed below.

Routine medical care treatment may include, but is not limited to, medical evaluation, physical exam, x-rays, and lab work (examples include: throat or nasal swabs, blood draws). Provider may give immunizations, allergy shots or intravenous antibiotics if a proxy is present.

I (we) request and authorize Provider and its personnel and contractors to deliver routine medical care as deemed necessary or advisable in the diagnosis and treatment of the child at Provider. The care is to be delivered to my child listed below while the above- appointed proxy is present:

Child's Name: _____ DOB: _____

LIMITATIONS

Identify any limitations on the kinds of medical services for which this authorization is given. [***Please also note if you want this preauthorization to be valid for less than 1 year.***] If nothing is specified, Provider is permitted to perform all routine medical care deemed medically appropriate by Provider within the scope of the above authorization.

_____

_____

Parental and Managing Conservator or Guardian (if applicable) contact information for questions regarding treatment:

Parent's Name: _____ Parent's Name: _____ _____

Daytime Phone _____ Daytime Phone _____

Evening Phone _____ Evening Phone _____

Cell Phone _____ Cell Phone _____

I release Provider and all its officers, agents, employees, contractors, attorneys, directors, insurers, affiliates, related corporations, successors, heirs and assigns of such corporations of any and all liability for acting in reliance on this authorization. The individual appointed as proxy (listed above) is permitted to make decisions or consent to care in my absence. I agree to assume financial responsibility for all care delivered and related costs and expenses. This consent is valid for one year (1) following the date signed below unless notice that it is withdrawn is provided in writing to Provider or restricted by the timeframe as noted above. Only one parent signature is required.

_____ _____

Signature of Parental and Managing Conservator or Guardian Signature of Parental and Managing Conservator or Guardian

Date _____ Date _____

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