CONSENT FOR TREATMENT OF MINORS IN ABSENCE OF PARENT(S) OR LEGAL GUARDIAN

Name of Minor: ___________________________ **Birth date:** ________________________ **Age:** ________

Please list Name and Contact Phone # for all parent/legal guardians of above named patient:

Parent/Guardian Completing Form: ________________________________ Relation: ______________ Phone #: ______________

Parent/Guardian Name: ____ Relation: ______________ Phone #: ______________

Parent/Guardian Name: ____ Relation: ______________ Phone #: ______________

I, the undersigned, am one of the legal guardians or parents with legal custody of the minor named above. I know that for the following reasons I may not be available to personally authorize medical care for said minor.

I hereby give my consent and authorization for any medical care that Victor Health Associates (The Practice) so determines as advisable, in the best judgment of health care providers. This care may include: scheduling appointments, accompanying child to appointments, consenting to medical procedures, emergency or non-emergency diagnostic procedures or tests, hospitalization, immunizations, mental health examination or treatment, *<u>payment for medical care - Payment is due at the time of service by the individual present with minor patient.</u>*

In my absence, I would like the health care provider to discuss the matter with the adults designated below. I authorize those persons, insofar as the law of New York State permits me to do so, to enter in to the decision, to convey to the provider my consent, and to consent to said treatment.

I hereby authorize the health care provider to discuss in full with those persons designated any medical information that is required to help the informed consent of the persons so designated. I have made and will make Victor Health Associates aware of any important medical facts to help health care providers in deciding what treatment is to be given. *<u>This does not authorize the listed individuals to sign further authorization forms on behalf of a minor patient to obtain or release protected health information.</u>*

I hereby hold harmless any health care provider of Victor Health Associates from any liability resulting from the failure to obtain consent from me as parent of the minor and from any other parent. It is my intent that the person or persons appointed herein shall be able to act in my stead in making such decisions.

I hereby appoint one person from the following list to be chosen in the order of priority listed, when the persons identified as parent/guardian of minor patient are not reasonably available, willing or competent to participate in the health care decision-making concerning the minor:

Name: ________________________________ Phone: ________________________________

Relation: ________________________________ Address: ________________________________

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Name: ________________________________ Phone: ________________________________

Relation: ________________________________ Address: ________________________________

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The period of time over which this authorization exists begins at signing and ends as follows:

☐ until _______/_______/______

OR

☐ until revoked by a parent/guardian in writing, or another form is submitted, or the child reaches the age of emancipation.

________________________________ ________________________________ ____________________

Signature of Parent/Guardian | Printed name of Parent/Guardian | Date

________________________________ ________________________________

Signature of Witness | Printed name of Witness (must not be family member or listed above)