Holland Hospital
PHYSICIAN OFFICES

Consent to Treat Minor

This form is to be used to allow an adult other than a parent to serve as a proxy decision maker for routine medical services at Lakeshore Health Partners.

Authorization:

I hereby appoint: _____ _____
Name Relationship

I hereby authorize the above appointed adult to consent to and authorize routine health care treatment and services for my child listed below.
I understand routine medical care, treatment and services may include, but are not limited to: medical evaluation, physical exam, immunizations, x-rays, and lab work.

I hereby empower and grant the decision maker appointed above, permission to consent to and authorize routine medical care as may be deemed necessary or advisable in the diagnosis and treatment of the minor child listed below and to receive protected health information directly relevant to, and for purposes of, his or her involvement in this care or payment related to this care.

_____ _____
Child's Name Date of Birth

Parental contact information:

_____ _____
Parent's Name Parent's Name

_____ _____
Daytime Phone Daytime Phone

I understand there is no obligation to contact me if the decision maker consents to the care. The individual appointed as decision maker herein is permitted to make decisions or consent to the care in my absence. I also agree to accept financial responsibility for all care and services delivered pursuant to this authorization. This authorization is valid for one year (1) following the date signed below unless withdrawn in writing to Lakeshore Health Partners. (Only one parent's signature is required)

_____ _____
Parent/Legal Guardian Signature Parent/Legal Guardian Signature

_____ _____
Date Date