PARENT AUTHORIZATION TO MINOR

For families who are ongoing patients of **Ironwood Family Practice.**

I (we) appoint, ____, who is my (our) child(ren)'s

____as my (our) proxy decision maker for consenting to medical care for my (our) children listed below. I (we) have the legal right to delegate such consent to the proxy decision maker, who is an adult and legally and medically competent to exercise the authority so delegated. Be advised that protected patient health information may be shared with the proxy to facilitate informed consent marking.

I am aware that I am responsible for all charges incurred at Ironwood Family Practice by my minor child.

Name: ____ DOB : ____________________________

Name: ____ DOB : ____________________________

Name: ____ DOB : ____________________________

Name: ____ DOB : ____________________________

LIMITATIONS

Identify any limitations on the kinds of medical services for which this consent by proxy is given. If none, state "none".____
____
____

CONTACT INFORMATION

If there is concern regarding the treatment being sought please try to contact me (us) regarding the health care of my child at the following telephone number(s). If you are unable for any reason, to contact me (us), you may rely on the proxy decision maker for consent.

Parents Name: _________________________________ Parents Name: _________________________________
Daytime Phone: ________________________________ Daytime Phone: ________________________________
Evening Phone: ________________________________ Evening Phone: ________________________________
Cell Phone: ____________________________________ Cell Phone: ____________________________________

IN WITNESS WHEREOF, the undersigned have executed this instrument as of the _____________.
(Date)

_________________________________ _________________________________
Parent or Legal Guardian Parent or Legal Guardian

_________________________________ _________________________________
Proxy Decision Maker Proxy Decision Maker Driver's License No.