



Consent For Treatment

This form is for families who are ongoing patients of PriMed Physicians.

I appoint _____, who is my child's
(Print Name) (Print Address)

_____ as (our) alternate decision-maker for consenting
(Specify nature of alternate's relationship to child)

to medical care for my child listed below. I have the legal right to delegate such consent to the alternate decision-maker, who is an adult and legally and medically competent to exercise the authority so delegated. Be advised that protected health information may be shared with the alternate to facilitate informed decision making. **This consent is valid until revoked in writing.**

Name _____ DOB _____
(Print child's Name) (Child's DOB)

Limitations

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

Contact Information

I (we) can be reached at the following numbers. If you are unable for any reason to contact me (us), you may rely on the alternate decision maker for consent.

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

Daytime Phone: _____ Daytime Phone: _____

Evening Phone: _____ Evening Phone: _____

Cell Phone: _____ Cell Phone: _____

(Print Name Parent or Legal Guardian)

(Signature Parent or Legal Guardian)

(Date)

(Signature Alternate Decision-Maker)

- Attach Copy driver's license alternate decision-maker.