PROXY CONSENT TO TREAT MINORS

For families who are ongoing patients of Riverbend HealthCare

Please review the following authorization for treatment and complete the information if you want to authorize such treatment for your minor children in advance. Be advised that protected patient health information may be shared with the proxy to whom the right to consent has been delegated to facilitate informed decision making.

I/we authorize _____ to serve as my/our proxy when our children are receiving medical treatment at Riverbend HealthCare.

I/we have the legal right to preauthorize Riverbend HealthCare to deliver medical treatment to my/our children listed below:

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Identify any limitations on medical services for which this authorization is given. If none, state "none."

_____

_____

If the nature of the medical care is not routine, please try to contact me/us regarding the health care of my/our children at the following telephone numbers. If you are unable for any reason to contact me/us, you may rely on the proxy decision maker for consent.

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

Daytime Phone: _____ Daytime Phone: _____

Evening Phone: _____ Evening Phone: _____

Cell Phone: _____ Cell Phone: _____

_____ _____

Parent or Legal Guardian Parent or Legal Guardian

_____ _____

Date Date