Orchard Medical Center, S.C.
Preauthorization to Treat Minor – CONSENT FORM

I / (We)____
(parent (s)/or legal guardian)
residing at____
(address of consenting parent(s) or legal guardian)
appoint ____
(authorized individual consenting to care when parent/legal guardian accompanying child not present at appointment)

who is my (our) child's ____
(specify nature of individual authorized to consent to care)

as my (our) proxy decision maker for consent to medical care for our child:

____
Name of Child DOB of Child

It may be more convenient to have prior authorization in place so that medical care may be delivered directly to minors if a parent or legal guardian cannot be present prior to treatment. Please review the following authorization for treatment and complete this form if you want Orchard Medical Center, S.C. to provide care to your child if you are not present at the scheduled appointment. Be advised that protected patient health information may be shared with the above proxy to whom you have appointed to consent to the care of your child at the appointment you are not at.

Limitations:

Please identify any limitations on the kind of medical care and services for which this authorization if given. If none, state "none".

Contact Information:

If the nature of the medical care/service is not routine please contact me (us) regarding the healthcare of my (our) child(ren) at the following telephone number(s). If you are unable for any reason to contact me (us) you may rely on the above proxy decision maker for consent.

Parent/Legal Guardian Name: Daytime No#:

Evening No#: Cell No#:

I (we) have read this consent and I (we) understand and agree with the requirements of me (us) and our assigned proxy. The information provided is true and accurate. I (we) hereby authorize Orchard Medical Center, S.C. to treat my (our) child. This consent form will remain in effect until we are advised you do not want to give consent to the above assigned proxy. If I (we) decide not to sign this consent form I (we) understand Orchard Medical Center, S.C. can not treat my (our) child without me (us) being present at the appointment.

The undersigned have executed this consent as of ________day of _____________,2___.

________________________________ ___________________________________
Parent or Legal Guardian Printed Name Signature of Parent or Legal Guardian

________________________________ ___________________________________
Assigned Proxy Decision Maker Signature of Proxy Decision Maker