



Hayden Lake FAMILY PHYSICIANS

8181 Cornerstone Dr. • Hayden Lake, ID 83835 • Telephone (208) 772-0785

Parent Authorization to Minor

For families who are ongoing patients of **Hayden Lake Family Physicians**.

I (we) appoint, _____, who is my (our) child's _____ as my (our) proxy decision maker for consenting to medical care for my (our) child 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 making.

I am aware that I am responsible for all charges incurred at Hayden Lake Family Physicians by my minor child:

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: _____
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.