AUTHORIZATION TO CONSENT TO ROUTINE AND EMERGENCY TREATMENT OF MY MINOR CHILD

I hereby authorize and grant permission to (Name)____, ("Proxy Decision Maker") who resides at (address)____to make decisions about and consent to the provision of routine care and acute treatment by Noble Community Clinics to my minor child.

Appointee's Phone Number: ____

My Child is: Child's Name:____DOB: __________________________

The Proxy Decision Maker is my child's (State Relationship to Child (i.e. aunt, grandmother): ____________________________

The Proxy Decision Maker shall only be acknowledged and accepted by Noble Community Clinics upon production of appropriate photo identification, such as a driver's license.

I have the legal right to delegate such permission to the Proxy Decision Maker, who is an adult and legally competent to exercise the authority so delegated. I understand that confidential protected patient health information may be disclosed to the Proxy Decision Maker to facilitate informed decision-making as to care to be provided to my minor child.

This Authorization shall become effective on the date executed below. Noble Community Clinics may rely on this Authorization to provide care to my child after that date. I hereby fully and irrevocable release and discharge Noble Community Clinics from liability for all appropriate medical/dental care provided to my minor child based upon reliance on this Authorization.

I understand that I may revoke this Authorization, in writing, at any time.

LIMITATIONS ON SCOPE OF AUTHROIZATION

Identify any limitations on the kinds of medical/dental services for which this Authorization is given. If none, state "none."

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Identify any limitations on the time frame for which this Authorization is given. If none, state "none."

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CONTACT INFORMATION

If the nature of the medical care to be provided to my child is not routine or acute care but is emergent and requires immediate medical/dental attention, please provide such care and then contact me regarding the emergent treatment at the following telephone numbers. If Noble Community Clinics is unable for any reason to contact me, Noble Community Clinics may rely on the Proxy Decision Maker to consent to all care for my minor child.

I further agree to reimburse Noble Community Clinics for the cost of rendering these services to the extent that my insurance does not pay for these services.

Parent's Name: __________________________________
Daytime Phone: _________________________________
Evening Phone: _________________________________
Cell Phone: ____________________________________

IN WITNESS WHERE OF, the undersigned has executed this Authorization as of the_____day of________________, 20____.

______________________________________	__________________
(Parent/Legal Guardian Signature)	Relationship
______________________________________	__________________
(Parent Legal Guardian Printed Name)	Date