PRE-AUTHORIZATION TO TREAT MINORS CONSENT FORM

This form allows Parents of Lake Norman Pediatrics to have a 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.

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.

AUTHORIZATION

I have the legal right to pre-authorize this facility to deliver medical treatment to my child. I request and authorize Lake Norman Pediatrics and its personnel to deliver care to my child listed below:

Name_______________________________________DOB__________________________

LIMITATIONS

Identify any limitations on the kinds of medical 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 is not routine, please try to contact me regarding the health care of my child at the following telephone numbers. If you are unable for any reason to contact me, you may rely on this proxy decision maker for consent.

Parent Name________________________________ Day Phone_________________________________

Cell Phone__________________________________ Evening Phone______________________________

Signature____Date________________

Parent Name________________________________ Day Phone_________________________________

Cell Phone__________________________________ Evening Phone______________________________

Signature____Date________________

Signature____Date_____________

Consent by Proxy

The consent by proxy form allows someone other than a parent the right to make medical decisions as if they were the parent. This form may be used to have a caregiver or grandparent bring your child to any visit, including a well child exam with vaccines and allergy shots.
This form should be completed for Step-parents.

CONSENT BY PROXY FOR NON-URGENT PEDIATRIC CARE FORM
I give **Consent by Proxy** to:

(1)____as my
(Name, phone#)
childs____as my proxy decision maker for consenting
(Relationship to child)

(2)____as my
(Name, phone#)
childs____as my proxy decision maker for consenting
(Relationship to child)

(3)____as my
(Name, phone#)
childs____as my proxy decision maker for consenting
(Relationship to child)

to non-urgent medical care for my child listed below. I 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 whom the right to consent has been delegated to facilitate informed decision making.

Name____DOB____________________

LIMITATIONS
Identify any limitations on the kinds of medical services for which this authorization is given. If none, state none.
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Time frame for which this authorization is given. If none, state none. Dates___________________TO____________________

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

Parent Name______________________________ Day Phone________________________________

Cell Phone________________________________ Evening Phone_____________________________

Signature____Date_________________

Parent Name______________________________ Day Phone________________________________

Cell Phone________________________________ Evening Phone_____________________________

Signature____Date_________________