ORTHOPEDIC CENTER of Palm Beach County

65 Years

Designation of Another Person to Consent of Treatment of a Minor Child

Minor Child
Full Legal Name: _____
Home Address: _____
Date of Birth: _____

Parent/Legal Guardian
Full Legal Name: _____
Home Address: _____
Telephone: _____ Relationship to Minor Child: _____

Designated Adult
Full Legal Name: _____
Home Address: _____
Telephone: _____ Relationship to Minor Child: _____

I, _____, am the parent or legal guardian of _____, who is minor child under age 18. By signing this form, I authorize _____ ("Designated Adult") to consent to or refuse any medical care or treatment for Minor Child that is recommended by The Orthopedic Center of Palm Beach County. I understand that my authorization is given prior to any medical treatment or recommendation. However, this authorization empowers Designated Adult with authority to exercise his/her best judgment upon the advice of The Orthopedic Center of Palm Beach County, and consent to or refuse any medical care or treatment for Minor Child.

I retain the responsibility for all charges by The Orthopedic Center of Palm Beach County resulting from Designated Adult's consent. I release The Orthopedic Center of Palm Beach County, and staff from any liability arising from this form and Designated Adult's consent to or refusal of treatment for Minor Child.

I understand that the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable State laws govern the disclosure of Protected Health Information (PHI). I acknowledge the necessity of disclosing Minor Child's PHI to Designated Adult, so Designated Adult can exercise his/her best judgment when consenting to or refusing medical treatment for Minor Child**. I authorized The Orthopedic Center of Palm Beach County to disclose Minor Child's PHI to Designated Adult.**

My authorization is effective until Minor Child reaches age 18, or until I revoke my authorization in writing.

Parent/Legal Guardian Signature: _____ Date: _____
Witness Signature: _____ Notary Signature: _____

Written Notice to Revoke Authorization

I, _____, am the original maker of this designation form. Upon signing this Written Notice, I no longer authorize _____ ("Designated Adult") to consent to or refuse any medical treatment for _____ ("Minor Child").
Parent/Legal Guardian Signature: _____ Date: _____