Compass Health Network

Delegation of Another Person to Consent for Treatment of a Minor or Incapacitated/Disabled Adult

Patient Name: _____ Date of Birth:_____

***Fill out this form if the patient is a minor and you (the guardian) would like other adults to be able to bring the child/ward to his/her appointments. ***

I, _____ (parent/legal guardian), cannot accompany my child,

_____ (patient name name) to Compass Health Network. Therefore, I give permission to the following adult(s) to bring my child/ward to his/her appointments:

*Person bringing child must be 18 years or older. *

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____(initials) I give permission for this person to seek treatment for my child/ward including any type of medical care, diagnostic test, mental health care, immunizations, procedure, and the administration of local anesthesia determined by a physician, nurse practitioner, or dentist, to be necessary for the welfare of my child/ward and provide consent **without having to contact me**.

This form will remain in effect until revoked by me. Please notify the office at any time if you would like to revoke this permission.

This form is **ONLY VALID** during the following timeframe:

Effective date: _____ Expiration date: _____

_____

Signature of Parent/Guardian Relationship Date

_____

Signature of Witness Date