OrthoArizona

DELEGATED AUTHORIZATION FOR TREATMENT OF A MINOR

I am the Parent/Legally Authorized Representative (LAR) of the minor named below ("Patient") and hereby designate the Adult Caregiver listed below to make all decisions that I am otherwise empowered to make on matters relating to the health care of the Patient. I acknowledge that I am responsible for all charges for care and treatment provided to the patient under this delegation.

Patient		
Patient First Name	Middle Name	Last Name
Patient Date of Birth: / /		
Parent/LAR		
Phone number(s) where Parent/LAR can be reached:		

Adult Caregiver (Person to whom you are delegating decisions to)		
Name	Relationship to Patient	
Street Address		Apartment
City	State	ZIP Code
Phone	Email Address	

As the Parent/LAR of the Patient, I agree to give the following powers to the Adult Caregiver:

Check One:

☐ I delegate, **without limitation**, all parental responsibilities I might perform myself, including giving or refusing consent to any medical treatment, radiology imaging and examination, anesthetic, medical or surgical diagnosis and treatment, hospital admission and discharge, physical therapy, occupational therapy, access to medical records, and other matters relating to the health care needs of the patient.

☐ I delegate only the specific parental responsibilities as follows:_____

_____

☐ Check here if you wish to give consent for the minor to receive non-surgical medical care without an accompanying adult. This consent may only apply to minors aged 16 years and older.

This authorization is:

Check One:

☐ effective until revoked by me in writing.

☐ effective from _____ to _____ dates only.

I have read, understand, and give my consent as described above. My signature means that I have read this form and/or have had it read to me and explained in the language that I can understand.

_____ _____

Signature of Parent/Legally Authorized Representative Date

_____ _____

Printed Name of Parent/Legally Authorized Representative Relationship to Patient