

DESIGNATION OF ANOTHER PERSON TO CONSENT FOR TREATMENT

Children should be brought in for treatment by a parent or legal guardian. However, there may be times when someone other than a parent or legal guardian will need to bring your child to the doctor. That person could be a baby-sitter, other family member or friend. During these times, if your child needs to be seen by a doctor, the person who brings your child in must be able to represent you in order to provide care.

By completing this form, you are designating who may bring your child in for medical care when you are unable to come with the child. **The person you designate to represent you must be 18 years of age or older.**

Instructions for Use of this Form

1. **Use a separate form for each person you choose to represent you.**
2. **Use a separate form for each child.**
3. Complete all the information on Pages 2 and 3 of this form for each child.
4. Sign and date the form. An adult must witness your signature. The witness can be any adult including the person you have chosen to represent you.
5. Give the completed form to the person(s) you have chosen to represent you. They must bring the form with them when they bring your child/children to the doctor.
6. A copy of the form will be kept in your child's medical record; however, the person(s) you have chosen to represent you should still bring a copy with them each time they come in with your child.
7. You have two options for the length of time the form is valid:
 - The form can be valid until you revoke it in writing, OR
 - The form can be valid for a designated time period.
8. To revoke the form, you will need to complete the required information on Page 4 and submit it the doctor's office.
9. Please make your designee aware that it is very important they obtain any patient instructions in writing before leaving the doctor's office. If you have questions about the instructions, please call the doctor's office.

YELLOW SPRINGS PRIMARY CARE
888 DAYTON STREET, SUITE 106 YELLOW SPRINGS, OH 45387
(937) 767-1088 OFFICE / FAX (937) 767-1022

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(Please Print)

I, _____, am unable to accompany my child
(Name of Parent/Legal Guardian)

_____ to Yellow Springs Primary Care. Therefore, I give
(Name of Child)
my permission to _____ as follows (check **ONE**):
(Name of Person)

I give permission for this person to seek treatment (including any type of minor procedure or diagnostic test, etc.) and provide consent for such treatment if attempts to contact me are unsuccessful.

I give permission for this person to seek treatment (including any type of minor procedure or diagnostic test, etc.) and provide consent for such treatment **without** having to contact me.

Expiration (check ONE):

This designation will remain in effect until I revoke it in writing by completing the information on Page 4.

This designation is valid **only** during the following time frame:

Effective From: _____ To: _____
(Starting Date) *(Ending Date)*

Signature of Parent or Legal Guardian

Date

Witness

Date

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NOTICE TO REVOKE

I, _____, am the parent/legal guardian of
(Name of Parent/Legal Guardian)

_____. Please immediately revoke prior permission for
(Name of Child)

_____ to consent for treatment of my child.
(Name of Person)

Effective From: _____ To: _____
(Starting Date) (Ending Date)

Signature of Parent or Legal Guardian

Date

Witness

Date

In order to process your Notice to Revoke, please bring this form with you to your next visit or fax it to (937) 767-1022

For Office Use Only

Revoked By (Employee Name): _____ Date: _____