Kids' Medical Care
Diana McLaughlin, MD
2336 Immokalee Road
Naples, FL 34110
239-591-8481

Name: ______________________________
MR#: ______________________________
DOB: ______________________________
Date: ______________________________

PREAUTHORIZATION TO TREAT MINORS CONSENT FORM

It may be more convenient to have 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. Please review the following authorization for treatment and complete the information if you want to authorize such treatment for your minor child in advance. 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 preauthorize this facility to deliver medical treatment to my child.
- I request and authorize this facility and staff to deliver medical care to 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 facilitate informed decision making.
- This form should not be considered without the advice of a lawyer.
- I appoint the following persons as my proxy decision maker for consenting to urgent or non-urgent medical care for my child.

Name: ______________________________
Address: ______________________________
____
Tel. #: ______________________________
Relation: ______________________________

Name: ______________________________
Address: ______________________________
____
Tel. #: ______________________________
Relation: ______________________________

LIMITATIONS

Identify any limitations on the kinds of medical services for which this authorization is given.
____

Identify any limitations on the time frame for which this authorization is given.
____

If the limitations above are left blank, it is assume there are **NO** limitations.

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 number. If you are unable for any reason to contact me, you may rely on the proxy decision maker for consent.

Mother's Name: ______________________________
Daytime Phone: ______________________________
Evening Phone: ______________________________
Cell Phone: ______________________________

Father's Name: ______________________________
Daytime Phone: ______________________________
Evening Phone: ______________________________
Cell Phone: ______________________________

Patient's Name ______________________________ **Date of Birth:** ____________________

I certify that the above information is correct at this time. I will promptly notify Kids' Medical Care of any changes in the above information.

Date: __________ Parent/Legal Guardian Print: ______________________ Sign: ______________________