Children's
of Alabama
1600 7th Avenue South
Birmingham, AL 35233

Permission for Non-Legal Guardian to Consent for Treatment

I represent that I am the parent/legal guardian authorized to make healthcare decisions for my child. I voluntarily grant the following Representatives to act in my proxy/place because I cannot accompany my child. I understand this means Children's of Alabama is not responsible for contacting me about this treatment or for my Representative's actions.

My Child's Full Name: _____ Date of Birth: _____

Address: _____

I hereby empower and grant the permissions below to the following REPRESENTATIVES:

_____ Date of Birth: _____
(Representative #1 Full Name)

Address: _____ Phone Number: _____

_____ Date of Birth: _____
(Representative #2 Full Name)

Address: _____ Phone Number: _____

YOUR REPRESENTATIVE MUST BRING THEIR VALID ID/DRIVER'S LICENSE
***YOU ARE RESPONSIBLE FOR PAYING YOUR BILLS.*

_____ (your initials) The Representative is authorized to consent for all medical and/or surgical treatment and/or other medical procedures (including administration of anesthesia, blood transfusions, diagnostic tests, vaccines, X-rays, etc.) for the above named child.

☐ For all clinic visits from _____ to _____ (cannot exceed 6 months)

_____ (your initials) I understand that the Representative will receive patient information and discharge instructions related to treatment rendered.

_____ (your initials) I understand that this authorization serves as the right for Representative to give permission for my child's treatment by The Children's Hospital, its employees, agents, and my child's physician(s) and/or his/her designated representatives.

_____ (your initials) **I understand that I am fully responsible for payment for all services provided to my child.** For example, if the patient has insurance this includes copays and deductibles. If you do not know these amounts, please contact your insurance company. I will also receive bills for other services, for example from the physician, or from procedures (such as radiology or anesthesia)

_____ (your initials) I may revoke (change my mind) on this authorization at any time. Any revocation must be in writing and directed to: Director, Medical Information Services, Children's of Alabama, 1600 7th Avenue South, Birmingham, AL 35233, Fax: (205) 939-9520.

The revocation will be effective upon receipt by the practitioners caring for your child. I understand that The Children's of Alabama and the physician(s) are not responsible for the action already taken due to reliance upon this authorization.

_____ (your initials) I have the authority to sign this authorization and am doing so voluntarily.
I do hereby release, indemnify, and do not hold responsible and/or liable, the physician(s), Children's of Alabama, and other persons who act in reliance upon this authorization.

_____ (your initials) I understand that completion of this form does not guarantee that Children's or other caregivers will accept this form as authorization to allow a non legal guardian to consent for certain procedures and/or treatment. Each submission of this consent by someone other than the legal guardian will be evaluated at the time of service and a determination of acceptance will be made solely by the care team.

Executed this _____ day of _____, 20____.

_____ _____
Parent/Legal Guardian Signature Printed Parent/Legal Guardian Full Legal Name

Parent/Legal Guardian's address and phone number(s): _____

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Verified by 2 adult Witnesses (adults who are not the Representative who see parent/legal guardian sign) or a Notary:

1st Witness

_____ _____ _____

Print Name Signature date (must be same as when parent/guardian signs)

_____ _____ _____

Print Name Signature date (must be same as when parent/guardian signs)

OR

Notary Seal:

Primary pediatrician Name:_____ Phone Number:_____

Chronic or existing medical conditions: (i.e., asthma, seizures, diabetes): _____

_____

Any known allergies:_____

Medications:_____

Insurance Information

Insurance Company Name.: _____Group Number:_____

Subscriber Identification:_____