Lifedoc Health
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Authorization From Legal Guardian to Assist Patients in Receiving Care

THIS FORM MUST BE COMPLETED FOR ANY PATIENTS THAT REQUIRE A LEGAL GAURDIAN PRESENT SUCH AS MINORS, CERTAIN HANDICAPPED INDIVIDUALS, ETC. DO NOT COMPLETE THIS FORM IF THE PATIENT IS AN ADULT AND NO LEGAL GAURDIAN IS REQUIRED TO BE PRESENT.

In the event that the patient has a legal guardian, this form allows specific individuals to assist the patient in receiving care at Lifedoc Health. The form must be completed and signed by the legal guardian of the patient in the event that a legal guardian is required to be present with the patient. This authorization will allow Lifedoc Health to discuss protected health information with the person designated below and the individuals may serve as proxy decision makers for the patient as needed.

Patient Name_____ DOB_____/_____/_____

The following people are authorized to bring my child in for treatment.

Name_____ Relationship to Patient _____

Name_____ Relationship to Patient _____

Name_____ Relationship to Patient _____

Name_____ Relationship to Patient _____

Unless otherwise identified above, no other individuals will be able to assist the patient in receiving medical treatment at Lifedoc Health. In the event of any issues arising the patient's legal guardian will be contacted using the information on file.

_____ By selecting this option you authorize the people above to serve as Proxy in decision making regarding the patients care

_____ By selecting this option you are stating that only the, the Legal Gaurdian/Responsible Party on file, should be contacted regarding the approval and consent of any medical care that is not considered routine.

This for shall have no expiration date _____

This authorization is only valid until _____/_____/_____

_____ _____

Patient's Name **Patients Signature**

_____ _____

Parent/ Legal Gaurdian Name **Parent/Legal Gaurdian Signature**

_____

Relationship to Patient (If other than self)