

For families that are ongoing patients of New Beginnings Pediatrics it may be more convenient to have a 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.

PREAUTHORIZATION TO TREAT MINORS CONSENT FORM

Be advised that protected patient health information may be shared with the proxy to whom the right to consent has been delegate to facilitate informed decision making.

AUTHORIZATION

I have the legal right to preauthorize this facility to deliver medical treatment to my child(ren). I request and authorize New Beginnings Pediatrics and its personnel to deliver care to my **child(ren)** listed below:

Name _____ DOB _____
Name _____ DOB _____
Name _____ DOB _____
Name _____ DOB _____

LIMITATIONS

Identify any limitations on the kinds of medical services for which this authorization is given. If none, state "none."

Identify any limitations on the time frame for which this authorization is given. If none, state "none."

CONTACT INFORMATION

If the nature of the medical care is not routine, please try to contact me regarding the health care of my child(ren) at the following telephone numbers. If you are unable for any reason to contact me, you may relay on this proxy decision maker for consent.

Parent Name _____
Evening Phone _____
Cell Phone _____
Phone _____

Parent Name _____
Evening Phone _____
Cell Phone _____
Phone _____

Signature _____ Date _____

For ongoing families of New Beginnings Pediatrics it may be convenient to have a caregiver or grandparent bring your child to any visit, even a well child exam. This is called consent by proxy. It gives someone other than a parent the right to make medical decisions as if they were the parent. If a Step parent will be bringing your child to appointments, the Consent by Proxy Authorization has to be completed. This is not our rule; step parents have not been given all parental rights in the state of Ohio yet.

CONSENT BY PROXY FOR NONURGENT PEDIATRIC CARE FORM

I give Consent by Proxy to:

(1) _____ as my
(Name and phone number)

child(ren)'s _____ as my proxy decision maker for consenting
(specify nature of proxy's relationship to children)

(2) _____ as my
(Name and phone number)

child(ren)'s _____ as my proxy decision maker for consenting
(specify nature of proxy's relationship to children)

(3) _____ as my
(Name and phone number)

child(ren)'s _____ as my proxy decision maker for consenting
(specify nature of proxy's relationship to children)

(4) _____ as my
(Name and phone number)

child(ren)'s _____ as my proxy decision maker for consenting
(specify nature of proxy's relationship to children)

to nonurgent medical care for my children 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 whom the right to consent has been delegate to facilitate informed decision making.

Children:

Name _____	DOB _____
Name _____	DOB _____
Name _____	DOB _____
Name _____	DOB _____

LIMITATIONS

Identify any limitations on the kinds of medical services for which this authorization is given. If none, state "none."

Identify any limitations on the time frame for which this authorization is given. If none, state "none."

PARENT CONTACT INFORMATION

If the nature of the medical care is not routine, please try to contact me regarding the health care of my child(ren) at the following telephone numbers. If you are unable for any reason to contact me, you may relay on this proxy decision maker for consent.

Parent Name _____	Parent Name _____
Day Phone _____	Day Phone _____
Evening Phone _____	Evening Phone _____
Cell Phone _____	Cell Phone _____

Signature _____ **Date** _____