PROXY CONSENT FOR ROUTINE CARE

SOURCE: __HIM_____

Release of Information fax: 205-383-1763

Purpose: This form may be used to allow an adult authorized by a minor patient's parent, patient living in group home setting or other legal guardian to serve as a proxy decision maker for routine medical care and services across Lakewood Health System's clinics and hospital, for outpatient hospital routine care.

For some families, it may be more convenient to have prior authorization established that allows Lakewood Health System to give routine medical care to minors and/or patient living in group home setting if a parent or legal guardian cannot be present to provide consent. However, such care must still be authorized by an alternative adult. This other adult is known as a Proxy Decision Maker. If you would like to appoint a proxy decision maker, please review and complete the following form authorizing a proxy decision maker to consent to and authorize medical treatment or services for and to be involved in the care of a minor child and/or patient living in group home setting. Also note that Minnesota law states that a minor can consent to their own care only in regards to conditions related to pregnancy and contraception, sexually transmitted infections, and substance abuse.

AUTHORIZATION: I hereby appoint:

_____*(name),* _____*(relationship),* as a proxy decision maker to consent to and authorize ***routine*** medical care treatment and services for my child(ren) or patient living in group home setting listed below at Lakewood Health System. ***Routine medical care and interventions may include, but are not limited to: medical evaluation, physical exam, x rays, lab work (examples include: throat or nasal swabs, blood tests and blood drawing), prescribing medications, wart treatment with liquid nitrogen, cleansing of minor burns, minor suturing of lacerations, removal of simple cysts, incision and drainage of abscesses***.

Lakewood Health System also may give **vaccinations, allergy shots or intramuscular/intravenous antibiotics** pursuant to the consent of the proxy. I hereby empower and grant the proxy decision maker appointed above permission to consent to and authorize routine medical care as may be deemed necessary or advisable in the diagnosis and treatment of the minor child or patient living in group home setting listed below and to receive protected health information directly relevant to, and for purposes of, his or her involvement in this care or payment related to this care. (More than one child may be listed.)

Child's name	Date of birth

LIMITATIONS: Identify any specific limitations on the kinds of medical services or duration for which this authorization is given. (If none, state "none".)

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I hereby indemnify and hold harmless Lakewood Health System, and all their officers, agents, employees, insurers, affiliates, subsidiaries, related corporations, and successors, from any and all liability for acting in reliance on this authorization. The individual appointed as proxy (listed above) is permitted to make decisions or consent to the care in my absence.

I also agree to accept financial responsibility for all care and services delivered pursuant to this authorization. This authorization is **valid for one (1) year following the date signed** below unless withdrawn in writing to Lakewood Health System or restricted by time frame as noted above.

Parent/guardian signature	Date
Print parent/guardian name	Date

This institution is an equal opportunity provider and employer.