Parent Authorization of Health Care Surrogate to Minor

I, ____, am the Mother/Father or Legal Guardian of ____ DOB: ______________________.

I authorize ____ to act as my surrogate when seeking or consenting for health care services provided by Providence Medical Group. Healthcare services may include but are not limited to: immunizations, medications, urgent and routine medical care, and minor procedures. I recognize that by approaching a surrogate to seek care for my child, my child's health care provider will communicate directly with my authorized surrogate and allow then to make decisions about my child's healthcare.

Therefore, I understand:

- It is my responsibility to communicate with my authorized surrogate regarding the care and follow up recommendations provided by my child's health care provider.
- My provider is not responsible for lack of communication or misinformation shared between my surrogate and myself regarding my child's care.
- If I have questions about the care of my child, I am encouraged to contact my child's health care provider for clarification at any time.

___________________________________ ______________________________ _____________

Signature Contact Phone Number Date

___________________________________ ______________________________

Surrogates Relationship to Patient Contact Phone Number

This consent shall remain in effect for ***<u>no more than 6 months from the date signed</u>*** on this document and can be revoked in writing by legal guardian. Providence Medical Group does not permit any more than two (2) authorized surrogates per child, ***<u>one surrogate per form</u>***.