



Delegation of Authority to Consent to Healthcare and Designation of Personal Representation

Dear Parent/Guardian:

Treatment of patients requires a team effort by the OSMC medical care provider(s) and the patient's parent or guardian. The parent or guardian's responsibility includes supporting the medical directives given by the medical provider. The medical provider's role includes ensuring that the parent or guardian is aware of and concurs with the treatment the patient receives.

While we encourage attendance of all appointments by parents or guardians, we understand that work and other life circumstances may occasionally prevent a parent/guardian from coming to an appointment. In an effort to balance patient needs and our medical responsibilities to ensure the optimal health care of our patients, we ask the following:

- A parent/legal guardian must attend a patient's first visit at OSMC.
- A parent/legal guardian must attend a patient's first visit for any new illness/injury.
- A parent /legal guardian must be in attendance for MRI, In-Office Procedures, Surgeries and IMPACT testing.
- If a parent/guardian is unable to accompany the patient, after the initial visit, then another authorized and responsible adult must accompany them. This Authorization and Informed Consent for Treatment of a Patient form must be signed by the parent and be on-file. Additionally, the parent/guardian must also agree to be available to be contacted by phone during the exam should the provider feel it necessary.
- In certain circumstances, the provider may require attendance by the parent/guardian if he/she feels that the nature of the content of the exam, the patient's ability to comprehend, etc. requires it. Therefore, even if the parent/guardian has authorized treatment, the provider may decline to see the patient without the parent/guardian in attendance at subsequent visits.
- Rehabilitation Services: After the initial therapy visit, arrangements may be made for patients over the age of 14 to attend therapy sessions without a parent, guardian or accompanying adult.

I authorize and give consent to OSMC for medical evaluation and treatment of the patient if a parent/legal guardian is not present.

Name of Patient: _____

Patient Birth Date: _____

Injury/Illness: _____

- ____ I/we hereby consent to the providing of any and all medical services other than surgical procedures without parent/legal guardian, but with another authorized and responsible adult present.
- ____ I/we hereby consent to the providing of Rehabilitation Services for a patient over the age of 14 without parent/legal guardian, or another adult present.
- ____ I/we acknowledge that we are responsible for all charges in connection with the care and treatment rendered.

Please list the name and relationship of the individual(s) authorized:

Name

Relationship

- | | |
|----------|-------|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |

Parent or Legal Guardian Signature

Date Signed

This form is valid for one year from date of signature.

Print Name of Parent or Legal Guardian

I hereby revoke this consent:

Parent or Legal Guardian Signature

Date of Revocation