PEDIATRIC EMERGENCY CONTACTS

Child's Last Name: _____ First Name: _____ Birth date: _____

Emergency Contact 1: _____

Relationship: _____ Phone #: _____

Emergency Contact 2: _____

Relationship: _____ Phone #: _____

AUTHORIZATION FOR NON-PARENT TO MAKE MEDICAL DEISIONS FOR MINOR CHILD

I authorize the following person(s) to bring my child to Hastings Internal and Family Medicine and make medical decisions for their care. (Please include any step parents)

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

AUTHORIZATION TO TREAT A MINOR CHILD AGE 16 OR OLDER WITHOUT PARENT OR GUARDIAN PRESENT

(For minor child age 16 or older please choose one below)

☐ **APPROVED.** When I am not here with my minor child age 16 or older the providers and staff of Hastings Internal and Family Medicine may give medications, perform procedures that are also needed for the health of my child and treat. I am aware that copays and deductibles may apply with my insurance, and that I will be responsible for the amount due.

☐ **DECLINED.** I decline to allow my minor child age 16 or older to come to appointments without a parent or guardian present.

SIGNATURE: _____ Date: _____

Printed name and relationship to the patient: _____

I understand that I have the right to revoke this authorization in writing at any time by sending such written notification to the practice's Privacy Contact at: Hastings Internal and Family Medicine 225 S M37 Hwy, Suite 1 Hastings, MI 49058. I understand that a revocation is not effective to the extent that my physician has relied on the use of disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I understand the above family members and/or friends may have limited access to my child's protected health information. I understand that I may revoke or change this consent at any time. I understand that it is the responsibility of the parent or guardian to maintain this list of names**. Any updates or changes require a new consent form be completed and signed by the biological parent/guardian ONLY**. I understand that the biological mother and father are always permitted to have access to my child's protected health information unless the parental rights of either the father or mother have been legally terminated.

SIGNATURE: _____ Date: _____

Printed name and relationship to the patient: _____