KAISER PERMANENTE®

Authorization for an Adult Caregiver to Consent to Medical Care for a Child

REQUESTOR

Name: _____

Address:_____

City: _____ State: _____ Zip Code: _____ Phone : _____

_____ I am the parent of the child listed below and there are no court orders now in effect which prohibit me from exercising the power that I now seek to convey.

_____ I am the legal guardian or custodian of the child by court order (copy attached, if available) and there are no other court orders now in effect which prohibit me from exercising the power I now seek to convey.

AUTHORIZATION

I am temporarily entrusting to : _____ _____
Full Name (Print) Relationship

An adult who resides at : _____

to care for the following child: **Patient Full Name**: _____

Date of Birth: _____ **Medical Record**: _____

The caregiver named above may consent to medical, surgical, and/or mental health diagnosis and treatment for the child, subject to any limitation listed below

_____

The authorization takes effect on (date)_____ and expires on (date) _____
(cannot exceed 12 months). Notification of intent to revoke must be in writing.

SIGNATURE

_____ _____ _____
Full Name (Print) Signature Date

If signed by other than parent, please indicate relationship to child. Submit document to show authority.

_____
Relationship to Child

Please fax the signed document to 855-889-3320 or E-Mail to MASHIEOPT@KP.ORG

80000148 Consent for Minor