KAISER PERMANENTE® **HAWAII REGION**

AUTHORIZATION TO ACCOMPANY AND/OR CONSENT TO LIMITED TREATMENT

Original: 12/2016 Revised:

MRN:

Name:

Date of Birth:

PATIENT IS A(N): ☐ **MINOR** ☐ **INCAPACITATED ADULT**

I. Fill out and Sign this section *TO AUTHORIZE INDIVIDUALS (16 and older) TO ACCOMPANY TO CLINIC VISITS*

Please note: Submitting this form will invalidate all prior authorizations to accompany and/or consent for treatment.

I, the undersigned parent ***OR*** legally authorized representative of: _____
(PRINT PATIENT'S FULL NAME)

Date of Birth: _____ ***Do hereby authorize the following individuals (☑ if person is < 18):***
DATE (MM / DD / YYYY)

1. _____ ☐ (PRINT NAME OF PERSON ACCOMPANYING PATIENT)
2. _____ ☐ (PRINT NAME OF PERSON ACCOMPANYING PATIENT)
3. _____ ☐ (PRINT NAME OF PERSON ACCOMPANYING PATIENT)
4. _____ ☐ (PRINT NAME OF PERSON ACCOMPANYING PATIENT)

To accompany the above named patient to his/her clinic visits. I understand that this delegation includes and authorizes receiving health information, including discharge instructions, related to services provided during clinic visits where the above named individual accompanied the patient.

This authorization to accompany remains in effect until terminated in writing by me; the patient regains legal capacity or reaches age of majority or my legal authority over the patient changes.

Payment for services rendered are due on date of service. I acknowledge responsibility to inform the authorized individuals that co-payments for visits are collected at check in and all other payments are due before leaving the clinic, and to make arrangements for payments to be made on date of service.

_____ (PRINT YOUR FULL NAME) _____ (YOUR SIGNATURE) _____ (RELATIONSHIP TO PATIENT) _____ DATE (MM / DD / YYYY)

II. Fill out and Sign this section *TO AUTHORIZE ACCOMPANYING ADULTS TO CONSENT TO TREATMENT*

I, the undersigned parent ***OR*** legally authorized representative of the above named patient:

Do hereby authorize the above named individuals (age 18 and above):

to also act as the representative(s) for the above named patient and to have the same full authority that I have to consent to, or withhold consent to, any primary and preventive medical care, immunizations, diagnostic testing and other medically necessary health care and treatment, which examination and treatment shall be prescribed by or under the supervision of a physician, podiatrist, optometrist, physician assistant, advanced practice nurse or mental health professional.

This authorization to consent to treatment shall remain in effect until

- _____ (no more than one (1) year from date of signature);
- The patient regains legal capacity or reaches the age of majority;
- This authorization to accompany and/or consent is terminated in writing by me and communicated to the healthcare provider in possession of this form; or
- my legal authority over the patient changes, whichever happens first.

_____ (PRINT YOUR FULL NAME) _____ (YOUR SIGNATURE) _____ (RELATIONSHIP TO PATIENT) _____ DATE (MM / DD / YYYY)

Please note: If this legal document is deemed to be invalid for any reason, the legal document will be returned to the responsible party listed below for completion and will NOT be scanned into KP's electronic medical record (KPHC)

III. Complete

I am filling this form out as the patient's:

☐ Parent ☐ Legally authorized representative (LAR) ☐ Court-appointed guardian

I can be contacted at: ***(please print legibly)***

_____ FIRST NAME _____ LAST NAME _____ PHONE NUMBER (xxx) xxx-xxxx

_____ ADDRESS _____ CITY _____ STATE _____ ZIP

For Kaiser Use Only: Check one: ☐ Add New ☐ Update

Verify responsible party's information:

1. Specify type of valid photo ID and/or legal documentation. ☐ Driver's license ☐ State ID ☐ Other_____
2. The person(s) named in section I above are >18. If person(s) named are 16-17, box must be checked. (<16 not allowed).
3. If parent/guardian/legal guardian/LAR not able to appear in person, a licensed health care professional must confirm completion of authorization over phone. Document confirmation date: ____ / ____ / ____.
4. Print Staff Name:_____ Loc/Dept:_____ Ph#: _____
5. Send to **Medical Records Administration / Dole**