KAISER PERMANENTE® *HAWAII REGION*

Appointment of Representatives Authorized to Consent to Treatment of a Minor

Original: 08/01/02 Revised: 08/01/10

MR#:

Name:

Sex/.BD:

1. **Print Legibly with Black Ball Point Pen.**
2. **Birthdays require a full year (YYYY).**
3. **The Canary copy of this form must be presented with the minor for ALL medical visits to Kaiser Permanente.**

I, The undersigned parent or legal guardian of:

(name of minor): _____

(birthdate): ___ / ___ / ___ (MM/DD/YYYY) Do hereby authorize the following individuals:

(name of representative 1): _____

(name of representative 2): _____

(name of representative 3): _____

(name of representative 4): _____

to act as the representative(s) for my child and to consent to admission and or treatment under the care of the attending physician, his/her associates, partners, assistants, designees, other staff, and/or contracted medical providers. I consent to any and all inpatient hospital and/or outpatient procedures including but not limited to x-ray examination, laboratory, anesthesia, emergency room services, medication, blood transfusion, blood component, drug testing removal and disposal of tissue, nursing or medical / surgical treatment that my physician, his or her associates, partners, assistants, or designees my deem necessary or advisable, under the general and special instructions of the same.

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.

This authorization shall remain in effect unless and until a written revocation is received by Kaiser Permanente Medical Care program, or until the age of majority of the minor referenced above, whichever occurs sooner.

Parent / Legal Guardian Signature: X _____ ____/ ____/ _____
Date (MM/DD/YYYY)

_____ ( ) _____ - _____
Relationship to Patient Telephone number

_____ _____ _____ _____
Address City State Zip code

For Kaiser Use Only: ☐ Add New ☐ Update

1. Verify parent or legal guardian's signature with a valid photo I.D. and/or legal documentation
2. Specify type of photo I.D. verified: ☐ Drivers License ☐ State I.D. ☐ Other_____
3. Print Staff Name: _____ Dept: _____ Ph#: _____
4. Send **to Patient ID / Dole**