STAMFORD HEALTH
Healing. Reimagined.

Affiliate: Columbia University College of Physicians and Surgeons
A Planetree Hospital
A Magnet® Recognized Hospital

DESIGNATION FROM

Date: _____/ _____/_____

I, _____, legal guardian of _____(list children's names or if over 18 years, write "myself") **give the following persons permission to make decisions regarding the necessary and or routine treatment** including but not limited to, examinations, injection, immunization, medication and/or diagnostic procedures, including x-ray or laboratory analysis. I also designate these persons to receive Protected Health Information (please see our Notice of Privacy Practices) including but not limited to any records of treatment, forms and prescriptions. I understand that only myself and those listed below will have the authority to authorize treatment and receive Protected Health Information.

I also authorize treatment (except for immunizations/injections) of my mature teen (16 years and older) without requiring the presence of an adult. However, if my teen needs immunizations and comes alone, a parent/guardian must be available by phone for verbal consent.

I authorize the release of Routine Childhood Immunization Records to Schools. Please note that a stepparent or grandparent does NOT have the legal right to consent for care unless designated below.

Name	**Phone Number #**	**Relationship to Patient**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand that any person not listed above bringing a patient who is a minor for treatment must have a letter of consent from me or treatment could be refused or delayed. I understand that in emergency, efforts will be made to contact me prior to the rendering of treatment, but that emergency medical treatment will not be withheld if I cannot be reached.

This authorization will remain in effect unless so designated in writing that such consent form treatment of minor is cancelled. I have read all the information on this sheet and have provided the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify the Stamford Health Medical Group, Pediatric Center PC of any changes in the health status of my children or the above information.

Whom may we contact in case of emergency, in addition to parent / guardian?

Children's' Names:_____ Date: _____/ _____/_____

Emergency Contact Name:_____

Relationship to Patient(s):_____

Home#:_____ Cell#:_____

Completed By_____

Signature: _____ Date: _____/ _____/_____