



1500000

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

DELEGATION OF AUTHORITY TO CONSENT FOR ROUTINE CARE AND TREATMENT FOR A MINOR

Instructions for completing this form: This form is designed for those situations where minors present for routine care and treatment unaccompanied by either a parent or legal guardian.

Patient's Name: _____

Patient's Address: _____

Date of Birth: _____ Medical Records Number: _____

Delegates with authority to consent to routine care and treatment:

Delegate: _____ Phone: _____

Address: _____

Relationship to patient: Grandparent Stepparent Other – Please Specify: _____

Delegate: _____ Phone: _____

Address: _____

Relationship to patient: Grandparent Stepparent Other – Please Specify: _____

Delegate: _____ Phone: _____

Address: _____

Relationship to patient: Grandparent Stepparent Other – Please Specify: _____

Delegates above may consent to immunizations for my minor child Yes No

The undersigned does hereby delegate to the persons identified above the authority to consent for routine care and treatment for the minor identified above. Routine care and treatment include, but is not limited to, physical and examinations, prescriptions, obtaining blood samples for laboratory studies, and x-rays. Routine care and treatment do not include minor procedures involving local anesthesia, and, unless specified above, it does not include immunizations. The care and treatment will be rendered under the general or special supervision of a UVA Health clinician. This delegation of authority to consent for routine care and treatment shall remain valid for 12 months unless revoked by a parent or legal guardian. To revoke this delegation, please call 434-924-5136.

Patient or Legal Representative Signature:

By signing below, I state that I am either a parent or legal guardian with the authority to consent to health care for the minor identified above. I have read or have had explained to me the contents of this form. I have had a chance to ask questions and all of my questions have been answered.

Signature _____ Printed Name _____ Date _____

Witness Signature: _____ *(Required Signature)

*Please note that without the required signature of the Witness, the form will not be recognized as Complete.

INTERPRETER ATTESTATION (when applicable)

Signature of Interpreter/Cyram ID# _____ Printed Name _____ Date/Time _____
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