Unity Care NW
Health Care for Everyone

ALTERNATE CARETAKER AUTHORIZATION FOR MINOR PATIENT

Authorization for Minor Patient to be Seen with an Alternate Caretaker

Patient Name (Print) _____ Patient Date of Birth (mm/dd/yyyy) _____

As the legally authorized representative, I give consent for the caretaker(s) listed below to make health care decisions in my absence.

Caretaker Name (Print)	Relationship to Minor Patient
1. _____	_____
2. _____	_____
3. _____	_____

Legally Authorized Representative Name (Print) _____

Legally Authorized Representative Signature _____ Date _____

In order to inform me of the risks and benefits of certain procedures, care may be limited by provider discretion. I can be contacted at the phone number below.

Home Address, City, State, Zip Code _____

( ) _____
Phone Number

STAFF USE ONLY: Authorization obtained by phone for: _____

Staff Name _____ Date _____

This consent will remain in effect unless I revoke it, give an expiration date, or specify reasons it will expire.
Optional: if you want this consent to expire, give the date or conditions below:

Expiration Date: _____

Condition for Expiration: _____