Unity Care NW
Health Care for Everyone

KINSHIP CARE AUTHORIZATION FOR MINOR PATIENT

Declaration of Relative / Kinship Responsibility for a Minor Patient's Health Care

Patient Name (Print)

Patient Date of Birth (mm/dd/yyyy)

DECLARATION

- I am 18 years of age or older.
- I am responsible for the health care of the minor patient.
- I am competent to make this declaration.
- I am a relative of the following minor child by blood, adoption, or marriage.
- I understand this declaration does not change the legally authorized representative's custody rights, or the minor patient's rights to consent own care when authorized by law.
- I consent treatment for the health care of this minor patient.

Relative / Kinship Information:

Name (Print)

Home Address, City, State, Zip Code

( )

Phone Number

My relationship to this minor patient is:

I declare under penalty of perjury under the laws of the State of Washington that the above is true and correct.

Relative / Kin Signature

Date

This declaration is only valid for 6 months from the date it is signed.
Use of this declaration is authorized by RCW 7.70.065

Last updated: 06/14//2019