Print Form

Maryland Primary Care Physicians

PROXY CONSENT TO TREAT MINORS FORM

Purpose: This form may be used to allow an adult other than a parent to serve as a proxy decision maker for routine medical care and services at the Maryland Primary Care Physicians, LLC clinics.

For some families, it may be more convenient to have prior authorization in place that allows routine medical care to be delivered to minors under the care of a proxy decision maker if a parent or legal guardian cannot be present to provide consent. If you would like to appoint a proxy decision maker, please review and complete the following form authorizing a proxy decision maker to consent to and authorize medical treatment or services for and to be involved in the care of a minor child.

AUTHORIZATION:

I hereby appoint _____ _____
NAME RELATIONSHIP

as a proxy decision maker to consent to and authorize routine health care treatment and services for my child(ren) listed below.

Routine medical care and interventions may include, but are not limited to: medical evaluation, physical exam, x-rays, lab work (examples include: throat or nasal swabs, blood draws, wart treatment with liquid nitrogen, cleaning of minor bums, minor suturing of lacerations, removal of simple cysts, contraceptive care, and incision and drainage of abscesses). Maryland Primary Care Physicians, LLC also may give immunizations, allergy shots or intramuscular/intravenous antibiotics pursuant to the consent of the proxy.
I hereby empower and grant the proxy decision maker appointed above permission to consent to and authorize routine medical care as may be deemed necessary or advisable in the diagnosis and treatment of the minor child listed below and to receive protected health information directly relevant to, and for purposes of, his or her involvement in this care or payment related to this care. *(More than one child may be listed)*

Child's Name:_____ DOB:_____

Child's Name:_____ DOB:_____

LIMITATIONS:

Identify any specific limitations on the kinds of medical services for which this authorization is given *(If none, state "none")*

_____

_____

Parental contact information for questions regarding treatment:

Parent's Name:_____ Daytime Phone:_____

Cell Phone:_____ Evening Phone:_____

Parent's Name:_____ Daytime Phone:_____

Cell Phone:_____ Evening Phone:_____

I hereby indemnify and hold harmless Maryland Primary Care Physicians, LLC, and all their officers, agents, employees, attorneys, directors, insurers, affiliates, subsidiaries, related corporations, successors, heirs and assigns from any and all liability for acting in reliance on this authorization. The individual appointed as proxy (listed above) is permitted to make decisions or consent to the care in my absence. I also agree to accept financial responsibility for all care and services delivered pursuant to this authorization. This authorization is valid for one year (1) following the date signed below unless withdrawn in writing to Maryland Primary Care Physicians, LLC or restricted by time frame as noted above. *Only one parent's signature is required.*

_____ _____ _____ _____
Signature of Witness Date Signature of Parent or Legal Guardian Date

_____ _____ _____ _____
Signature of Witness Date Signature of Parent or Legal Guardian Date