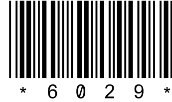
MR # DOB

NAME

DATE



BASSETT HEALTHCARE NETWORK
☐ **BASSETT MEDICAL CENTER**
Cooperstown, NY 13326-1394
☐ **LITTLE FALLS HOSPITAL**
Little Falls, NY 13365
☐ **TRI TOWN REGIONAL HOSPITAL**
Sidney, NY 13838

CONSENT BY PROXY FOR NONURGENT PEDIATRIC CARE

H-6029 12/03;5/04 (d:\forms\hosp\.doc)

Health Center: ________________________

I (we) appoint____, who is my (our)
(Name) (address)
child's____ as my (our) proxy decision maker for
(specify nature of proxy's relationship to child)

consenting to **nonurgent** medical care for my (our) child listed below. I (we) have the legal right to delegate such consent to the proxy decision maker, who is an adult and legally and medically competent to exercise the authority so delegated. Be advised that protected patient health information may be shared with the proxy to facilitate informed decision making.

Child's Name: ____ DOB: ______________________________

LIMITATIONS

Identify any limitations on the kinds of medical services for which this consent by proxy is given. If none, state "none".

____

____

____

Identify any limitations on the time frame for which this consent by proxy is given.

____

____

____

CONTACT INFORMATION

If the nature of the medical care is not routine, please try to contact me (us) regarding the health care of my (our) child at the following telephone number(s). If you are unable for any reason to contact me (us), you may rely on the proxy decision maker for consent.

Parent's Name:______________________________ Parent's Name:______________________________

Daytime Phone:______________________________ Daytime Phone:______________________________

Evening Phone:______________________________ Evening Phone:______________________________

Cell Phone:______________________________ Cell Phone:______________________________

____ ____
Parent or Legal Guardian Parent or Legal Guardian

____
Proxy Decision Maker

CONSENTS

Original – Chart **Copy -** Parent