3RD PARTY CONSENT

Purpose of this form: *Allows a patient to authorize another individual to access their medical information or act on their behalf regarding healthcare matters.*

I. Patient Information

Full Name of Patient: _____ Date of Birth: _____

II. Parent/Guardian Information (complete only if the patient is a minor)

Full Name of Parent/Legal Guardian: _____

Relationship to Minor: _____ Phone Number: _____

Address: _____

III. Authorized Third Party Information

Full Name of Authorized Third Party: _____

Relationship to Patient: _____ Phone Number: _____

Address: _____

IV. Authorization of Medical Decision-Making and Access

I, _____ hereby authorize _____ to:

Full Name of Parent/Guardian if patient is a minor, or Full Name of Patient if an adult

Full Name of Third Party

SELECT ALL THAT APPLY:

- ☐ Make medical decisions/consent to medical treatment, including vaccinations, on behalf of the patient.
- ☐ Schedule/Cancel medical appointments for the patient.
- ☐ Request/pick-up the patient's medical records and information.
- ☐ Communicate with healthcare providers regarding the patient's care.
- ☐ Other (please specify):_____

V. Duration of Consent

This authorization is valid one year from date of signature.

VI. Revocation

I understand that I may revoke this authorization at any time by providing written notice to the healthcare provider or institution. Revocation will not affect any actions taken based on this authorization before the receipt of the written revocation.

VII. Signature of Parent/Guardian/Patient

By signing below, I affirm that I have the legal authority to authorize the individual named in this form to act on behalf of the patient, and I consent voluntarily.

Patient/Guardian Signature: _____ Date: _____