



Prior Authorization for Proxy Consent to Treat Minor Patients



At Olympic Medical Physicians (OMP) clinics, we require the consent of a parent or legal guardian to provide most types of routine care for patients under the age of 18. Having prior authorization in place allows us to deliver medical care to minors under the care of proxy decision maker if you, as the parent or legal guardian, cannot be present to provide consent. Please carefully review and complete this form if you would like us to care for your child when the child is brought in by another adult you choose.

Minor Patient Information

Minor Patient Name: _____ Date of Birth: _____

This authorization applies when an adult listed below brings the minor patient to an OMP clinic:

Name of Adult	Relationship to Minor	Phone Number

Authorization to Treat a Minor Patient

I am the parent or legal guardian of the minor patient named above. I give advance authorization and consent for the minor patient receiving routine or emergency health care treatment considered necessary by clinical staff. This includes any care, service, or procedure provided by the clinical staff to diagnose, treat, or maintain physical or mental condition.

By checking this box, I also give advance authorization and consent for the minor patient to receive vaccinations recommended by clinical staff.

I do not authorize the following kinds of medical services

(List services you do not wish to authorize without your presence – if none, write “none”):

I, the parent or legal guardian, will communicate with the minor patient and adult listed above about the care provided, diagnostic findings, and treatment plan and I will follow up on any treatment plan and medications.

I, the parent or legal guardian, agree to assume financial responsibility for all expenses of the care provided. I may revoke this authorization at any time by contacting the OMP clinic. I indemnify and hold harmless Olympic Medical Center, OMP, and all their officers, agents, employees, directors, insurers, affiliates, from any and all liability for acting in reliance on this authorization.

This authorization will be valid for 90 days or until: _____

Printed Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____ Date Signed: _____

Daytime Phone: _____ Evening Phone: _____