Boston Children's Hospital

DELEGA * M R Q 2 2 4 *

Use Plate, Label, or Print:

Name:

BCH MRN#:

DOB: Gender:

Delegation of Authority to Consent to Health Care Services

As the parent or guardian of the child listed below, I will be unavailable for the purpose of providing consent for any medical and/or mental health services that is provided to my child.

Therefore, I delegate my authority to the individual (Delegate) below to have full power, authority, and discretion to make any and all health care consultation, treatment, and/or care coordinating decisions regarding the medical and/or mental health services for my minor, without any limitations. This authorization shall include consent for admission, discharge, and/or transfer at Boston Children's Hospital (BCH) or another health care facility.

I further authorize the individual below to release to, discuss with, and/or receive health information from one or more health care providers at BCH or another health care facility, physician office or institution, and rely on the medical discretion of the providers in consenting for any medical and/or mental health services for my child.

Furthermore, I hereby agree that any third party receiving a copy of this document via mail, fax, or other electronic means, shall follow the direction of the individual listed below. Unless so listed here, there shall be no limitations on the delegation of authority.

LIMITATIONS: _____

I understand that there may be health care to which my delegate may consent but to which I may not have consented were I available. I agree to hold BCH and my child/ward's clinical team harmless for failure to obtain my consent to any health care services administered to my child or ward if such health services was provided with my delegate's consent. I further understand that if my child or ward requires any emergency services, BCH may provide such treatment without obtaining consent from me or my delegate.

This delegation is effective from _____to _____ (may not exceed 60 days).

Name of Child		Date of Birth:	
Name of Parent or Guardian:			
Parent Signature:		Date:	
Witness Name:			
Witness Signature:		Date:	
Name of Delegate:			
Delegate Address:			
Delegate Telephone:			