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