Friends of Family
Health Center

Authorization for Caregiver/Guardian

This is an important legal form. Before signing this form, you should understand the following facts:
This form gives the person you choose as your child's agent the authority to make all health care decisions for you, except to the extent you say otherwise in this form. "Health care" means any treatment, immunizations, service or procedure to diagnose or treat your child's physical or mental condition.

I, ________________________________, the parent of ________________________________, patient's DOB _____/_____/_______ hereby appoint ________________________________, who is the patient's (state relationship); ________________________________, as my child's ***only*** health care agent (proxy). This proxy is effective ONLY when either biological parent is unable to bring the child to receive health care services.

Appointee's Address: ____

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Appointee's Phone number: ____

Unless I revoke it or state an expiration date or my child turns 18 years of age, this proxy shall remain in effect for one (1) year from the date signed. Optional, if you want this proxy to expire, state the date or conditions here.

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Initials

The Appointee acknowledges the ***responsibility to pay*** for medical services provided in accordance with the medical health care center's policies.

________________________________ ________________________________
Parents Name Parents Signature

____
Date

501 S. Idaho St., Suite 100, La Habra, CA 90631
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Revised 6/26/2014 fi