TULIP TREE
FAMILY HEALTH CARE

DELEGATION OF AUTHORITY TO CONSENT TO HEALTHCARE OF MINOR

Patient Name: _____ **Date of Birth:** _____

I, _____, **parent/guardian of** _____
Authorized Parent/Guardian' Child

delegate[2] **to the following individuals the authority to consent to healthcare for my child during any period of time when I am not reasonably available.**

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

I understand that the above-named individual(s) are authorized to make any and all healthcare decisions on behalf of the Child. These decisions include, but are not limited to, authorizing access to, and authorizing the disclosure of, any and all confidential health care information relating to the Child.

I understand it is my responsibility to communicate with the individual(s) indicated above that are making medical decisions for my child, both to agree to the necessary information to share with medical providers and to learn all the recommendations the providers may make for my child.

This Delegation may be rescinded by providing a written, signed, statement to Tulip Tree Family Healthcare at any point in the future.

_____ **Date:** _____
Signature

WITNESS: I declare that at the request of the Parent/Guardian, I witnessed the signing of this document.

DATED: _____ **Signature** _____

Printed Name _____

[1] **Pursuant to Indiana Code: LC. 16-36-1-S(b) at http://iga.in.gov/legislative/laws/2022/ic/titles/016#16-36-1-5**
[2] **Pursuant to Indiana Code: LC. 16-36-1-6 at http://iga.in.gov/legislative/laws/2022/ic/titles/O 16#16-36-1-6**