Porter PHYSICIAN GROUP

DELEGATION OF AUTHORITY TO CONSENT TO HEALTH CARE FOR MINOR

I/We, _____as _____, of minor child under the
Print name of Parent **Relationship to Patient**

age of eighteen (18) years, do hereby delegate _____ an adult
Consenting adult name

of_____ County, State of Indiana, all health care decisions to be rendered to the above named minor under the general or special supervision and on the advice of any physician/provider licensed to practice medicine in the State of Indiana. This authority is delegated due to my/our unavailability to exercise this authority in person or by telephone. This delegation of authority will begin on _____ and shall expire at midnight (date) _____ (not to exceed 30 days) unless it is revoked in writing prior to that time. I/we understand that I/we will be responsible for all costs incurred for any and all medical care rendered to this minor child. The authority to consent to treatment herein is subject to the following conditions or exclusions:

_____

_____
Minor Child Name Printed

_____ _____
Parent/ Guardian Signature **Date**

Note: Signature of delegated adult must be compared by driver's license at the time of service at any of the Porter Physicians Group locations.

_____ _____
Delegated Adult Signature **Date**