AUTHORITY TO CONSENT BY PERSON OTHER THAN PARENT OR LEGALLY AUTHORIZED REPRESENTATIVE

Children's Hospital Colorado requires a patient's parent, guardian, or legally authorized representative ("LAR") be present at patient appointments. While it is important for the parent or LAR to be present for all visits, this is not always possible. This form may be used as a Power of Attorney ("POA") to allow another adult to serve as a substitute decision-maker ("Substitute") for you to consent for medical care, as allowed by C.R.S. § 15-14-105. This Form will remain in effect for the dates specified below, unless you revoke it.

I, _____ (print full name) **am the Parent or LAR of the minor child or incapacitated person named below:**

_____, _____/_____/_____ _____

(Print Patient's Full Name) (Patient's Date of Birth) (My Relationship to Patient)

I hereby authorize and appoint _____ (print Substitute's full name) **the authority to consent for medical, dental, and mental health and to act in my place as follows.**

Substitute's Phone Number:_____ Relationship to Patient: _____

I authorize the Substitute to consent for the following care, condition(s), procedure(s), and/or treatment(s):

☐ All medically necessary medical, dental, and mental health care, or

☐ Only the following: (for example, emergency care, well-child check-up, dental cleaning and exam, etc.)

List: _____

For the following date(s): _____

Note: Unless otherwise stated, this Form is effective immediately once signed. If the patient is a minor (under 18), the dates listed must be no later than twelve (12) months from the date this Form is signed.

Limitations: Please identify any limitations on the kinds of health care services for which this authorization is given. If none, please state "none."

_____

By signing below, I authorize the Substitute to consent for medical, dental, and mental health care for the patient as stated above and as recommended by the treating health care providers. I understand that treating providers may still seek parent/LAR's verbal consent for major health care decisions. I consent to the sharing of the patient's protected health information and records with the Substitute. I agree to accept financial responsibility for all care and services delivered pursuant to this Form.

_____ _____ _____/_____/_____

Parent/LAR Signature Parent/LAR Phone Number Date Signed