RIVER VALLEY
FAMILY HEALTH CENTERS

AUTHORITY TO CONSENT BY PERSON OTHER THAN PARENT OR LEGALLY AUTHORIZED REPRESENTATIVE ("FORM")

River Valley Family Health Centers (RVFHC) requires a parent or legally authorized representative to be present at the initial patient appointment for a minor child (i.e., someone who has not had his/her 18th Birthday). While it is important for the parent or legally authorized representative of a minor child to be present for all visits, we realize that this is not always possible. This Form may be used to allow an adult, other than a parent or legally authorized representative, to serve as a substitute decision maker ("Substitute") for non-emergent medical care at RVFHC as allowed by Colorado Revised Statute (C.R.S.) 15-14-105. If you would like to appoint a Substitute, please review and complete this Form and return it to the check-in staff at the front desk or fax this form to our Health Information Management department at 720-777-7244. This Form will remain in effect for the dates specified below, unless you revoke it in writing.

Authorization:

As the Parent or Legally Authorized Representative of:_____(the "Minor").
(Patient's Name and Date of Birth)

I request that authority to consent be granted to:_____(the "Substitute").
(Name)

_____ _____ _____
(Street Address) (City, State, Zip Code) (Phone Number)

Whose relationship to the Minor is: _____.

**Note: Only a stepparent, adult relative of first or second degree of kinship, or an adult childcare provider who has care and control of the minor may consent for immunization of a minor child, per C.R.S. § 25-4-1704*

** Note: Authority to consent may not be granted to an individual other than a parent or legally authorized representative for major health care decisions as determined by the Minor's health care provider.*

☐ **If approving all non-emergent, non-major care rendered at RVFHC, please check the box.**

☐ **If approving just for the following care, condition(s), procedure(s), and/or treatment(s) (e.g., well-child check-up, dental cleaning and examination, etc.) please list here:**

_____

_____

☐ **If you would like to be contacted in the event a medical decision needs to be made for additional, unanticipated medical services beyond the reason for the patient's visit, please check the box.**

Limitations:

Please identify any limitations on the kinds of medical services for which this authorization is given, or any limitations on the time frame for which this authorization is given. If none, please state "none."

_____

_____

This form is effective from_____ ____ _____to_____ ____ _____

** Note: Unless otherwise stated, this Form is effective immediately once signed. The dates listed must be no later than ninety (90) days from the date of this Form. In no event will this Form be in effect for a period longer than ninety (90) days from the date the parent or legally authorized representative signs the Form.*

By signing below, I confirm that the Substitute to whom I have given consenting authority has the ability to obtain, process, read, and understand health information so that an appropriate and informed health care decision can be made. I understand that if the treating medical providers have any doubts as to the capability of the Substitute to provide permission for medical care, they may defer non-urgent/non-emergent care until appropriate permission may be obtained. By completing this Form, I consent to the sharing of the Minor's protected health information with the Substitute. I agree to accept financial responsibility for all care and services delivered pursuant to this Form.

Signature of Parent or Legally Authorized Representative	Relationship	Date	Time

Printed Name of Parent or Legally Authorized Representative	Phone Number	Alternate Phone Number

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This section to be completed by RVFHC staff:

☐ Identification of Substitute verified (State Identification Card or Government Issued ID)

Place Patient Identification Label Here