GUNNISON VALLEY FAMILY PHYSICIANS
CERTIFIED AMERICAN BOARD OF FAMILY PHYSICIANS

Alternate Caregiver Consent Form

I authorize the following individual(s) to bring my children to their appointments:

Name:_____ Relationship to child:_____

Name:_____ Relationship to child:_____

Name:_____ Relationship to child:_____

Name:_____ Relationship to child:_____

I attest that the above named individual(s) are all 18 years of age or older as of this date.

I authorize the above named individual(s) to consent to treatment for my child. This may include, but is not limited to, consent for necessary medications, immunizations, procedures, and hospitalizations. Gunnison Valley Family Physicians may relay any medical information, including protected health information, about my child that is necessary for the above named individual(s) to provide informed consent to the treatment.

I understand that the doctor will communicate his or her findings and treatment plan to the caregiver who bring my child and that under circumstances a follow-up call to me personally should not be necessary. I agree to be responsible for any fees for services requested by the above named individual(s) when permitted by my insurance carrier(s).

I agree to hold Gunnison Valley Family Physicians and its staff harmless for any disagreement between the above named individual(s) and myself regarding treatment decisions.

I attest that I am the parent or legal guardian of the following children and that I have the legal authority to make this agreement. I understand that I can revoke this authorization for any or all of the above listed individual(s) at any time:

Children covered by this consent:

Name:_____ Date of birth:_____

Name:_____ Date of birth:_____

Name:_____ Date of birth:_____

Name:_____ Date of birth:_____

Name:_____ Date of birth:_____

Parent / Guardian's Name (print):_____ Date:_____

Parent / Guardian's Signature:_____