ALTERNATE CAREGIVER AUTHORIZATION FORM

Patient (Minor) Name: _____

Patient Date of Birth: _____

Parent/Guardian Name: _____

Alternate Caregiver Name: _____

Aspirus Entity: _____

The patient's parent/guardian provides authorization to the alternate caregiver listed above to consent to medical care for the patient at any Aspirus facility or location where appropriate and necessary care may be necessary. If I am a parent, I attest that I have legal custody of the minor.

Authorizations can be no longer than one month in length and may be revoked at any time.

Authorization Date: _____

Revocation Date (if shorter than one month): _____

I hereby release and hold harmless the physicians, employees and other persons who act in reliance on this authorization.

_____ _____

Parent/Guardian Signature Date

ALTERNATE CAREGIVER AUTHORIZATION RECEIVED BY PHONE (when necessary)

Parent/Guardian Name: _____

Alternate Caregiver Name: _____

Employee Obtaining Phone Consent: _____

Date: _____

Time: _____