Premier Community HealthCare Group, Inc. (PCHG)

DESIGNATION OF HEALTH CARE SURROGATE FOR MINOR FOR NON-URGENT PEDIATRIC CARE

This form may only be used for established patients.
Legally responsible parent(s)/custodian(s)/guardian(s) are required to attend first visit with minor child.

All sections must be completed for authorization to be valid.
Please print all information except where signature is required.

Section 1 – Minor's Information

Name: ______________________________ Date of Birth: ______________________

Section 2 – Parent(s)/Custodian(s)/Guardian(s) Information

I/We, (print name/s)______________________________, ______________________________, the

- ☐ natural guardian(s) as defined in s. 744.301(1), Florida Statutes;
- ☐ legal custodian(s);
- ☐ legal guardian(s);

of the minor named above, pursuant to s. 765.2035, Florida Statutes, designate the person named in Section 3 to act as my/our surrogate for health care decisions in the event that I/we am/are not able or reasonably available to provide consent.

Section 3 – Designation of Health Care Surrogate for Minor

Surrogate's Name: ______________________________

Surrogate's Address: ______________________________

Surrogate's Phone: ______________________________

Section 4 – Scope of Authorization

I/We authorize PCHG to follow the instructions of my/our surrogate for the following care provided the treatment is on the advice of a licensed practitioner. If the nature of care is not routine, we will make every attempt to contact you, but if we are unable to speak with you, we will rely on the decision of your designated surrogate.

☐ Medical care only, except for the following limitations (if none, state "none"):

____

☐ Dental care only, except for the following limitations (if none, state "none"):

____

☐ Medical and Dental care, except for the following limitations (if none, state "none"):

____

Section 5 – Duration of Authorization

This authorization is valid:

- ☐ for today's visit only
- ☐ for the following time frame: ____
- ☐ indefinitely, until revoked

Section 6 – Notification of Surrogate

I/We will notify and send a copy of this document to the following person(s) other than my/our surrogate, so that they may know the identity of my/our surrogate:

Name: ____ Phone: _______________________

Name: ____ Phone: _______________________

Section 7 – Parent(s)/Custodian(s)/Guardian(s) Signature(s)

By signing below, I/We fully understand that this designation will permit my/our designee to make health care decisions for a minor and to provide, withhold, or withdraw consent on my/our behalf, to apply for public benefits to defray the cost of health care, and to authorize the admission or transfer of a minor to or from a health care facility.

Signature (1): ____ Date:_________________________

Signature (2): ____ Date:_________________________

Section 8 – Witnesses

To be valid, this completed form and signatures above must be witnessed by two adults (the designated surrogate and PCHG employees are prohibited from acting as witnesses for this purpose):

Witness (1)

Printed name: ____

Signature: ____

Date: ____

Witness (2)

Printed name: ____

Signature: ____

Date: ____