HALIFAX HEALTH
303 N. Clyde Morris Blvd., Daytona Beach, FL 32114
1041 Dunlawton Ave., Port Orange, FL 32127

Patient Name
Adm. Date Dr.
Date of Birth Age Sex
MR # Visit #

APPOINTMENT OF SURROGATE FOR A MINOR

As the parent / legal guardian of _____, a minor,

I hereby designate _____ to act as my surrogate in making health care decisions concerning the care and treatment of my child in the event I cannot accompany my child to a medical or psychiatric appointment. This includes medical and psychiatric treatment (including the prescribing of psychotropic medications). The named surrogate shall have the authority to consent to all care and treatment as determined to be in the best interest of my child. I am also aware any bill produced is my responsibility as the child's legal guardian (unless official court documentation is provided stating otherwise).
I hereby indemnify and hold harmless the physicians, hospitals, and other persons who act in reasonable reliance upon this authorization. This authorization shall be valid until revoked by me in writing.

_____ _____
Parent / Legal Guardian Signature Date

Parent Name (printed): _____

Address:_____

Phone Number: _____

Surrogate Name: _____

Address:_____

Phone Number: _____

Child's Name:_____

Birthdate:_____

Known Allergies: _____

Current Medications:_____

Primary Care Physician/Phone: _____

_____ _____
Witness Signature Date Witness Signature Date

_____ _____
Witness (Printed Name) Witness (Printed Name)

HMC 753