

MEDICAL TREATMENT AUTHORIZATION

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This Medical Treatment Authorization (this "**Authorization**") is made as of [EFFECTIVE DATE] (the "**Effective Date**") by:

[PARENT/GUARDIAN LEGAL NAME], residing at [PARENT/GUARDIAN ADDRESS], who is the parent or legal guardian (the "**Authorizing Parent**") of the minor child identified below; and, where two parents or guardians sign,

[SECOND PARENT/GUARDIAN LEGAL NAME], residing at [SECOND PARENT/GUARDIAN ADDRESS] (together with the Authorizing Parent, the "**Authorizing Parents**").

This Authorization concerns [MINOR LEGAL NAME], a minor born on [MINOR DATE OF BIRTH] (the "**Minor**"), and names [CAREGIVER LEGAL NAME], residing at [CAREGIVER ADDRESS] (the "**Caregiver**"), as the adult authorized to act for the Minor during the period stated below.

Recitals. The Authorizing Parents will be temporarily unavailable to make or communicate medical decisions for the Minor and wish to empower the Caregiver to consent to medical, surgical, dental, and related care for the Minor in their absence. The Authorizing Parents intend this Authorization to give medical providers the assurance they need to treat the Minor promptly. In consideration of the matters described below, the Authorizing Parents agree and authorize as follows.

1. Identification and Relationship

1.1 The Minor. The Minor is [MINOR LEGAL NAME], born [MINOR DATE OF BIRTH], currently residing at [MINOR ADDRESS]. The Minor's sex assigned at birth, height, weight, and other identifying details are: [OPTIONAL IDENTIFYING DETAILS].

1.2 Authority of the signer. Each Authorizing Parent represents that he or she is the biological parent, adoptive parent, or court-appointed legal guardian of the Minor and has full legal authority to consent to the Minor's medical care. If a court order, custody decree, or guardianship affects this authority, it is identified here: [CASE/ORDER REFERENCE, IF ANY].

1.3 The Caregiver. The Caregiver is the adult the Authorizing Parents trust to exercise the authority granted here. The Caregiver's relationship to the Minor is [RELATIONSHIP, e.g. grandparent, aunt, family friend] and the Caregiver's date of birth is [CAREGIVER DATE OF BIRTH].

2. Scope of Authorization

2.1 Grant of authority. The Authorizing Parents authorize the Caregiver to consent to and arrange for medical, surgical, dental, diagnostic, hospital, mental health, and emergency care for the Minor, including examination, anesthesia, diagnosis, and treatment recommended by a licensed physician, dentist, or other qualified health care provider.

2.2 Routine and emergency care. This authority covers both routine care (such as checkups, immunizations, and treatment of minor illness or injury) and urgent or emergency care needed to address a condition that, in the judgment of a treating provider, requires prompt attention.

2.3 Limits on authority. The Caregiver may **[NOT]** consent to the following without first attempting to reach an Authorizing Parent: **[LIST ANY EXCLUDED PROCEDURES, e.g. elective surgery, blood transfusion, psychiatric admission]**. If no limits apply, write "None." Any limit does not prevent treatment a provider deems immediately necessary to prevent serious harm.

2.4 No obligation on providers. Nothing in this Authorization requires any provider to render care, and providers retain professional discretion consistent with applicable law and their standards of practice.

3. Effective Period

3.1 Term. This Authorization is effective from **[START DATE]** through **[END DATE]**, unless it is revoked earlier under Section 9 or unless a shorter or longer period is required by local law.

3.2 Continuing emergencies. If an emergency arises before the end date and treatment continues past that date, this Authorization remains effective for that episode of care until the Minor is stabilized or returned to an Authorizing Parent's care.

3.3 Renewal. The Authorizing Parents may renew this Authorization by signing a new dated document. This Authorization does not automatically renew.

4. Insurance and Financial Responsibility

4.1 Insurance information. The Minor is covered by the following health insurance: carrier **[INSURANCE CARRIER]**, policy or member number **[POLICY NUMBER]**, group number **[GROUP NUMBER]**, primary insured **[PRIMARY INSURED NAME]**. A copy of the insurance card **[IS / IS NOT]** attached.

4.2 Responsibility for costs. The Authorizing Parents remain financially responsible for the cost of the Minor's care, including copayments, deductibles, and amounts not covered by insurance. The Caregiver is not personally responsible for these costs unless the Caregiver agrees in a separate writing.

4.3 Authorization to bill. The Authorizing Parents authorize providers to submit claims to the Minor's insurer and to release information necessary to obtain payment.

5. Medical Background

5.1 Known conditions. The Minor has the following known medical conditions, allergies, and sensitivities: **[LIST CONDITIONS AND ALLERGIES, OR "NONE KNOWN"]**.

5.2 Current medications. The Minor currently takes: **[LIST MEDICATIONS AND DOSAGES, OR "NONE"]**.

5.3 Primary physician. The Minor's primary care provider is **[PHYSICIAN NAME]**, phone **[PHONE]**, address **[ADDRESS]**. The Minor's preferred hospital or pharmacy is **[PREFERENCE, IF ANY]**.

5.4 Reliance. Providers may rely on the information in this Section as accurate. The Authorizing Parents will update the Caregiver if it changes before the end date.

6. Consent to Share Health Information

6.1 Disclosure to the Caregiver. The Authorizing Parents authorize providers and the Minor's insurer to disclose to the Caregiver health information about the Minor that is reasonably necessary to obtain and coordinate care,

consistent with applicable privacy law.

6.2 **Scope.** This consent covers diagnoses, treatment records, test results, and billing information related to care rendered during the effective period.

6.3 **Privacy law.** This Section is intended to satisfy any patient authorization required under applicable health-information privacy laws of [STATE] and the United States. It does not waive any protection the Minor would otherwise have.

7. Emergency Contacts

7.1 **Reaching the Authorizing Parents.** Providers and the Caregiver should attempt to reach an Authorizing Parent at: phone [PARENT PHONE], alternate phone [ALTERNATE PHONE], email [PARENT EMAIL].

7.2 **Secondary contact.** If an Authorizing Parent cannot be reached, contact [SECONDARY CONTACT NAME], relationship [RELATIONSHIP], phone [SECONDARY CONTACT PHONE].

7.3 **No delay.** The inability to reach a listed contact does not prevent the Caregiver from consenting, or a provider from rendering, care that is immediately necessary.

8. Acknowledgments and Indemnification

8.1 **Good-faith reliance.** The Authorizing Parents acknowledge that providers and the Caregiver will rely on this Authorization in good faith and agree that such reliance is reasonable.

8.2 **Hold harmless.** To the fullest extent permitted by applicable law, the Authorizing Parents will not hold the Caregiver liable for decisions the Caregiver makes in good faith under this Authorization, except for the Caregiver's gross negligence or willful misconduct.

8.3 **No medical advice from this document.** This Authorization grants consent only. It is not medical advice and does not direct any particular course of treatment.

9. Revocation, Governing Law, and General Provisions

9.1 **Revocation.** An Authorizing Parent may revoke this Authorization at any time by delivering written notice to the Caregiver. Revocation does not affect care already rendered or care underway in an emergency.

9.2 **Governing law.** This Authorization is governed by the laws of the State of [STATE], and the requirements of local law govern the form, witnessing, and notarization of consents for a minor's care where they differ from this document.

9.3 **Witness or notarization.** If local law or a provider requires a witness or notary, the Authorizing Parents will complete the block below as required.

9.4 **Severability.** If any provision is unenforceable, the remaining provisions stay in effect.

9.5 **Counterparts and electronic signature.** This Authorization may be signed in counterparts and by electronic signature, each of which is an original.

IN WITNESS WHEREOF, the Authorizing Parent(s) have signed this Authorization as of the Effective Date.

AUTHORIZING PARENT / GUARDIAN

SECOND PARENT / GUARDIAN (if any)

Signature: _____

Signature: _____

Printed name: **[NAME]**

Printed name: **[NAME]**

Title/Relationship: **[PARENT / LEGAL GUARDIAN]**

Title/Relationship: **[PARENT / LEGAL GUARDIAN /
N/A]**

Date: _____

Date: _____

Caregiver acknowledgment (optional).

CAREGIVER

Signature: _____

Printed name: **[NAME]**

Date: _____

Witness / Notary (if required by local law).

WITNESS OR NOTARY

Signature: _____

Printed name: **[NAME]**

Title: **[WITNESS / NOTARY PUBLIC]**

Date: _____

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