

# CATSKILL REGIONAL MEDICAL CENTER

## AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR TEMPORARILY SEPARATED FROM PARENT/GUARDIAN

I/We, the undersigned, custodial parent(s)/guardian(s) of \_\_\_\_\_,  
(Print name of minor)  
a minor, do hereby authorize \_\_\_\_\_,  
(Print name of camp or facility)

or any authorized representative thereof, as our agent(s) to act in my/our name, place and stead in any way in which I/we could do, if I/we were personally present, with respect to said minor, including, without limitation, giving consent to any diagnostic procedure or medical care which is deemed advisable by, and is to be rendered under the general or special supervision of, any licensed physician or surgeon on the staff of or engaged by Catskill Regional Medical Center, whether such diagnosis or treatment is rendered at the office of said physician or at Catskill Regional Medical Center.

With respect to consent to diagnostic procedures or medical care, it is understood that this authorization is given in advance of any specific need for treatment but is given to provide authority on the part of my/our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the physician in the exercise of his/her best judgment may deem advisable.

This authorization shall remain effective until \_\_\_\_\_, 2\_\_\_\_, unless sooner revoked in writing and delivered to said agent(s).

\_\_\_\_\_  
(Signature of custodial parent or guardian)

\_\_\_\_\_  
(date)

\_\_\_\_\_  
(Signature of custodial parent or guardian)

\_\_\_\_\_  
(date)

\_\_\_\_\_  
(Witness)

\_\_\_\_\_  
(date)

### Custodial Parent(s)/Guardian(s) Contact Information

Name: \_\_\_\_\_

Permanent Address: \_\_\_\_\_

Temporary Address: \_\_\_\_\_

Phone numbers: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Mobile: \_\_\_\_\_

Insurance Carrier/Plan: \_\_\_\_\_ Policy/I.D.#: \_\_\_\_\_

Insurance company address/phone #: \_\_\_\_\_

NOTE: THIS DOCUMENT MUST BE MADE PART OF THE PATIENT'S MEDICAL RECORD