

WICHITA UROLOGY

ALTERNATE CAREGIVER CONSENT FORM | AUTHORIZATION FOR MEDICAL CARE

I authorize the following individual(s) to bring my child(ren) to their appointments (other than parents):

Name: _____ Relationship to child: _____

I attest that the individuals listed above are 18 years of age or older as of this date.

I authorize the above-named individual(s) to consent to medical treatment for my child(ren). This may include, but is not limited to, consent for necessary medications, immunizations, procedures, and hospitalization. *Wichita Urology may relay medical information, including protected health information (PHI), to the above-named individual(s) only as needed for them to provide informed consent to treatment.* I understand that the provider will communicate their findings and treatment plan directly to the caregiver bringing the child.

I agree to hold Wichita Urology, and its staff harmless for any disagreement between the above-named individual(s) and myself regarding treatment decisions.

I attest that I am the parent or legal guardian of the child(ren) listed below and that I have the legal authority to make medical decisions on their behalf:

Children covered by this consent:

Patient's name: _____ Date of Birth: _____

Patient's name: _____ Date of Birth: _____

Patient's name: _____ Date of Birth: _____

Parent / Guardian's Name

Parent / Guardian's Signature

Date