BIG ISLAND Healthcare
ECARE Hawaii LLC

AUTHORIZATION TO ACCOMPANY AND/OR CONSENT TO LIMITED TREATMENT

Patient is a(n): ☐ Minor ☐ Incapacitated Adult

I. Fill out and Sign this section **TO AUTHORIZE INDIVIDUALS (18 and older) TO ACCOMPANY TO CLINIC VISITS**
*Please Note: Submitting this form will invalidate all prior authorizations to accompany and/or consent for treatment

I, the undersigned parent OR legally authorized representative of: _____
(PRINT PATIENT'S FULL NAME)

Date of Birth:_____ Do hereby authorize the following individuals:

1. _____ (PRINT NAME OF PERSON ACCOMPANYING PATIENT)
2. _____ (PRINT NAME OF PERSON ACCOMPANYING PATIENT)
3. _____ (PRINT NAME OF PERSON ACCOMPANYING PATIENT)
4. _____ (PRINT NAME OF PERSON ACCOMPANYING PATIENT)

To accompany the above-named patient to his/her clinic visits. I understand that this delegation includes and authorizes receiving health information, including discharge instructions, related to services provided during clinic visits where the above-named individual accompanied the patient.

This authorization to accompany remains in effect until terminated in writing by me; the patient regains legal capacity or reaches age of majority or my legal authority over the patient changes.

(PRINT YOUR FULL NAME) (YOUR SIGNATURE) (RELATIONSHIP TO PATIENT) DATE (MM/DD/YYYY)

II. Fill out and Sign this section **TO AUTHORIZE ACCOMPANYING ADULTS TO CONSENT TO TREATMENT**

I, the undersigned parent OR legally authorized representative of the **above-named patient** do hereby authorize the **above-named individuals** (**age 18 and above**) to also act as the representative(s) for the above-named patient and to have the same full authority that I have to consent to, or withhold consent to, any primary and preventive medical care, immunizations, diagnostic testing and other medically necessary health care and treatment, which examination and treatment shall be prescribed by or under the supervision of a physician, podiatrist, optometrist, physician assistant, advanced practice nurse or mental health professional.

This authorization to consent to treatment shall remain in effect until

- _____(no more than one (1) year from date of signature)
- The patient regains legal capacity or reaches the age of majority;
- The authorization to accompany and/or consent is terminated in writing by me and communicated to the healthcare provider in possession of this form; or
- My legal authority over the patient changes, whichever happens first

(PRINT YOUR FULL NAME) (YOUR SIGNATURE) (RELATIONSHIP TO PATIENT) DATE (MM/DD/YYYY)

III. Complete

I am filling this form out as the patient's:
☐ Parent ☐ Legally authorized representative (LAR) ☐ Court-appointed guardian ☐ Child Protective Services (CPS) social worker

I can be contacted at: (please print legibly)

FIRST NAME LAST NAME PHONE NUMBER (XXX) XXX-XXXX

MAILING ADDRESS CITY STATE ZIP

For Office Use Only: ☐ New ☐ Update
Verify responsible party's information:
1. Valid photo ID and/or legal documentation. ☐ Driver's License ☐ State ID ☐ Other_____
2. Person(s) named ≥
3. If parent/guardian/legal guardian/LAR not able to appear in person, a license health care professional must confirm completion of authorization over phone. Document confirmation date:_____/_____/_____