HERITAGE
PEDIATRICS, PLLC

8031 Broadway
San Antonio, Texas 78209
www.HeritagePediatrics.com
Phone: (210) 804-2301
Fax: (210) 805-9523

Advance Consent to Treat Minors

***Purpose**: This form allows a Parent or Legal Guardian to authorize limited medical consent by a designated non-guardian caregiver **only when the Parent or Legal Guardian cannot be reached within a reasonable time**. This form supplements the Household Patient Demographics Information Form and does not replace it.*

Patient Household Reference

*This authorization applies to the child(ren) listed on the **Household Patient Demographics Information Form** currently on file with Heritage Pediatrics, PLLC.*

Authorized Caregiver(s)

(Examples include grandparents, nannies, babysitters, step-parents, close family friends, or other trusted adults who may bring your child for care but are not legal guardians)

*I authorize the following individual(s) ("Authorized Caregiver") to consent to **routine medical evaluation and treatment** for my minor child(ren) at Heritage Pediatrics **when I cannot be reached within a reasonable time**.*

Name of Authorized Caregiver	***Relationship to Child(ren)***	***Phone Number***
_____	_____	*(____)*_____
_____	_____	*(____)*_____

Scope of Authorized Consent

Authorized Caregivers may consent to medical care deemed necessary by the treating provider, including but not limited to:

- *Office visits and examinations*
- *Diagnostic testing and laboratory studies*
- *Imaging studies*
- *Medications and injections*
- *Minor in-office procedures*

*This authorization **does not** include consent for elective surgical procedures, hospitalization, or anesthesia outside the scope of routine outpatient pediatric care.*

Advanced Consent Financial Responsibility (Important)

Authorization to consent to treatment ***does not transfer financial responsibility****. All financial responsibility remains with the Parent or Legal Guardian as documented on the Household Patient Demographics Information Form and the Financial Policy.*

Duration and Revocation

This authorization is provided in advance of any specific diagnosis or treatment and remains in effect unless revoked in writing by the Parent or Legal Guardian.

Acknowledgments

- *This form applies only when a Parent or Legal Guardian cannot be reached within a reasonable time.*
- *A copy of this authorization shall be treated as valid as the original.*
- *This authorization does not limit the rights of the Parent or Legal Guardian when present.*

Authorizing Parent or Legal Guardian

I am a Parent or Legal Guardian with legal authority to consent to medical care for the child(ren) listed on the Household Patient Demographics Information Form.

Name (print): _____

Relationship to Child(ren): _____

Parent or Legal Guardian Signature: _____ Date: _____