



2018 Clinch Avenue
P.O. Box 15010
Knoxville, TN 37901
p. 865-541-8000

Did you know no one caring for your children can authorize their medical care without your written permission? If you would like another adult to be able to bring your child to Children's Hospital and its practices for care, complete this form, have it notarized and leave it with your caregiver.

Authorization to Obtain Medical Treatment

I authorize (full name) \_\_\_\_\_

of (full address) \_\_\_\_\_

to give consent during my absence for my child(ren) listed below to be hospitalized, have surgery or receive other necessary health care. I also authorize Children's Hospital and it's providers and staff to share my child's protected health information (PHI) with the person named above as necessary. This authorization will expire two years from the date I sign below, unless I revoke it sooner in writing. The authorization will end sooner if the child turns 18 before the authorization expires.

Child's full name: \_\_\_\_\_
Date of birth: \_\_\_\_\_
Child's physician/phone number: \_\_\_\_\_
Important medical history (chronic conditions, allergies, etc.): \_\_\_\_\_

Child's full name: \_\_\_\_\_
Date of birth: \_\_\_\_\_
Child's physician/phone number: \_\_\_\_\_
Important medical history (chronic conditions, allergies, etc.): \_\_\_\_\_

Child's full name: \_\_\_\_\_
Date of birth: \_\_\_\_\_
Child's physician/phone number: \_\_\_\_\_
Important medical history (chronic conditions, allergies, etc.): \_\_\_\_\_

Name of parent(s) or guardian(s): \_\_\_\_\_

Address of parent(s) or guardian(s): \_\_\_\_\_

Phone number of parent(s) or guardian(s): \_\_\_\_\_

Signature of parent(s) or guardian(s): \_\_\_\_\_

Date: \_\_\_\_\_

NOTARY:

STATE OF TENNESSEE, COUNTY OF \_\_\_\_\_

SUBSCRIBED and sworn before me, a Notary Public, this \_\_\_\_\_

day of \_\_\_\_\_, 20 \_\_\_\_\_

Notary: \_\_\_\_\_

My commission expires: \_\_\_\_\_