

Her Health OBGYN

Temporary Guardian Authorization

I, _____, as parent or
NAME OF PARENT OR GUARDIAN

guardian for _____, do authorize as
NAME OF PATIENT

my child's temporary guardian, _____
NAME OF TEMPORARY GUARDIAN

to consent to medical treatment by the provider, and her assistants, or her designee of Her Health OBGYN as necessary in her judgment. This consent includes routine, diagnostic procedures and medical treatment of conditions requiring medical care. This consent is effective for the period of time from (date) _____ to (date) _____.

I am aware my temporary guardian will be required to provide a photo ID on arrival at Her Health OBGYN.

I assign Her Health OBGYN all benefits payable under the medical expense provision of my insurance. If my insurance benefits do not cover the entire expenses, I will be responsible to Her Health OBGYN for payment of the entire bill. I understand that I may receive separate bills from pathologists, labs or other entities for professional services provided.

I authorize Her Health OBGYN, members of it's staff, administrators and officials to furnish my health insurance company or it's representatives any information pertaining to the routine care, illness or injuries sustained by my child and the treatment for which she receives medical care.

Parent or Legal Guardian (Print Name) _____

Relationship to Patient: Mother Father Legal Guardian

SIGNATURE OF PARENT OR LEGAL GUARDIAN

DATE

Telephone number where I can be reached _____