{MINORS ONLY}: Authorization for Another Adult to Make Health Care Decisions for My Child

I/We, _____ and _____,
am/are the

☐ parent(s) (natural guardian(s), ☐ legal custodian(s), ☐ legal guardian(s) Of:

Child's Name: _____ Date of Birth: ____/_____/_____

Under **Florida law (s. 765.2035 and s. 744.301(1))**, I/We allow the following person to make medical, dental, and behavioral health decisions for my/our child if I/we are not available:

Primary Authorized Individual(s):

Name	Address	Phone Number

Backup Authorized Individual(s) (if the primary person is unavailable):

Name	Address	Phone Number

What This Means

- I/We allow **Heart of Florida Health Centers (HFHC)** to follow the instructions of the person(s) listed above for my child's medical care, including medicines, treatments, and procedures.
- These individuals can make health care decisions for my child, apply for benefits to help pay for care, and approve hospital or clinic transfers if needed.
- I/We understand that HFHC is **not responsible** for any decisions made by the person(s) listed above.
- I/We can cancel this permission at any time in writing.

Who Can Bring My Child for Care: By Florida law, **stepparents, grandparents, adult siblings, aunts, or uncles** can bring a child for medical care **without special permission.**

☐ I do NOT want this provision to apply. I want ONLY the person(s) listed in the tables above to be allowed to bring my child for care.

Print Name: _____ Relationship with Patient: ☐ Self ☐ Parent ☐ Legal Custodian ☐ Legal Guardian Date: ___/___/_____

Signature: _____

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