

MINOR CARE AUTHORIZATION

Permission for Another Adult to Assist With My Child's Care

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 authorize the individual(s) listed below to make medical, dental, and behavioral health decisions for my/our child if I/we are not available.

Please list all adults you want authorized to bring the child for care or make health care decisions (for example: parents, grandparents, or other caregivers).

Primary Authorized Individual(s)

| Name | Address | Phone Number |
|------|---------|--------------|
| | | |
| | | |

Backup Authorized Individual(s)

| Name | Address | Phone Number |
|------|---------|--------------|
| | | |
| | | |

What This Authorization Allows

By signing below, I/We understand and agree that:

- Heart of Florida Health Centers (HFHC) may follow the instructions of the authorized individual(s) listed above regarding my/our child's care.
- These individuals may consent to medical, dental, and behavioral health treatment, medications, diagnostic tests, and procedures.
- These individuals may apply for benefits to assist with payment for care and approve transfers or referrals if needed.
- HFHC is not responsible for decisions made by the authorized individual(s).
- This authorization may be revoked at any time by providing written notice to HFHC.

Bringing a Child for Care (Florida Law)

Under Florida law, certain family members (such as stepparents, grandparents, adult siblings, aunts, or uncles) may bring a child for care without prior written authorization.

I do NOT want this provision to apply. Only the individual(s) listed above may bring my child for care unless I/we provide separate authorization.

Printed Name: _____

Relationship to Patient: Self Parent Legal Guardian Legal Custodian

Signature: _____

Date: ___ / ___ / ___