Designation of Another Person to Consent for Treatment for an Adult

It is best that patients are brought for treatment by a parent or legal guardian. However, there may be times when someone other than you takes care of the patient. That person may be a family member, caregiver, etc. If the patient must be seen at Fairfield Medical Associates during these times, we need the person who brings the patient to be able to sign a consent form for Fairfield Medical Associates to provide care. Any adult bringing the patient in for treatment MUST have a valid photo ID.

This form allows the person you choose to seek treatment and sign consent for the patient when you are unable to come with the patient. **The person must be 18 years of age or older**. **Please note that anyone not listed as the insurance policy holder cannot sign any financial paperwork and this must be completed prior to initial appointment or the appointment will be rescheduled.** This can be completed via our website www.fairfieldmedical.com and returned via mail, fax, or brought in at time of the appointment. If mailing or faxing documents please call prior to the appointment to verify the information was received.

How to use this form:

1. Make several copies of this form.
2. Complete all of the information on page 2 of this form. Use a separate form for each patient.
3. Sign and date the form and have an adult witness your signature. The person who will accompany the patient can be the witness of your signature, but it can also be someone else.
4. Give the completed form to the person you have chosen. Have the person bring this form when he or she brings the patient to Fairfield Medical Associates. Please fill out a separate form for each person who may bring the patient.
5. This form is kept in the patient's chart.
6. By checking the appropriate box below, you can choose to have this form be valid until you revoke it or only during a designated time period.
7. If you have a need to revoke this form, please complete the information required on page 3.
8. Be sure to tell the person who comes with the patient to get the doctor's and assistant's instructions in writing before leaving Fairfield Medical Associates. If you have questions about the instructions, be sure to call the office and speak with the physician's medical assistant.
9. The address to mail paperwork is Fairfield Medical Associates, 1781 Countryside Drive, Lancaster, Ohio 43130. The fax number for Fairfield Medical Associates is 740-475-0598 and the office number is 740-687-8600.
10. **All copays must be paid at the time of the appointment. If the copay cannot be paid at the time of the visit the appointment will be rescheduled.**

I, (parent/legal guardian)_____, cannot accompany (patient's name)_____, to Fairfield Medical Associates. Therefore, I give permission to (person's name)_____as follows (check one):

☐ I give permission for this person to seek treatment (including any kind of procedure, immunizations, testing, etc.) and provide consent for such treatment if attempts to contact me are unsuccessful.

☐ I give permission for this person to seek treatment (Including any kind of procedure, immunizations, testing, etc.) and provide consent for such treatment without having to contact me.

Expiration of Permission (check one)

☐ This form will remain in effect until revoked by filling out the form on page 3.

☐ This form is VALID ONLY during the following timeframe:

Effective date:_____ /Expiration date:_____

X_____ _____

(Signature of parent or legal guardian) (Date and time signed-required)

X_____ _____

(Signature of witness-18 years of age or older) (Date and time signed-required)

Address_____

Home Phone_____ Work Phone_____

NOTICE TO REVOKE "DESIGNATION OF ANOTHER PERSON TO CONSENT FOR TREATMENT" FORM

I, (parent/legal guardian) _____, am the parent or legal guardian of (patient's name) _____. Please immediately revoke prior permission for (person's name) _____ to consent for treatment.

X_____ _____

(Signature of parent or legal guardian) (Date and time signed-required)

X_____ _____

(Signature of witness-18 years of age or older) (Date and time signed-required)

Address_____

Home Phone_____ Work Phone_____

In order to process your Notice to Revoke, please bring this form with you to your next visit or fax it to our office at 740-475-0598.

OFFICE USE ONLY

Revoked by (staff name):_____

Date:_____