TERRY REILLY
Your Health. Our Mission.

DELEGATION OF AUTHORITY TO MAKE HEALTH DECISIONS

Name of **Minor or Incapacitated Patient:**	DOB:

Name of **Parent of Guardian of Patient:**	
Address:	Phone Number:

Name of **Individual Authorized** to obtain care:	
Address:	Phone Number:

1. I am the parent, guardian, or otherwise have legal authority and responsibility for making health care decisions for the minor or incapacitated person listed at the top of this form.
2. I authorize and grant to the Individual listed as authorized above a special, limited power of attorney to seek and consent to health care, receive health care information, and otherwise make health care decisions for this patient. This form creates a special power of attorney per Idaho Code § 15-5-104 and is subject to the following limits or restrictions:

   ☐ No limitations or restrictions ☐ As listed:_____
3. This form is effective for the following time period, unless it is canceled in writing and notice is given to the health care provider: From_____Until_____, or for 6 months if no dates are filled in.
4. The minor or incapacitated person listed at the top of this form has the following allergies, health care conditions, or special needs that may affect and/or be related to their health care:

   ☐ None ☐ As listed:_____
5. I understand and agree that I will be personally responsible for any charges or fees for health care provided using this form. I agree to hold harmless from any liability the person authorized above and any health care provider who relies on this document when providing treatment.

_____ _____
Signature of Patient or Guardian Date

_____ _____
Signature of Witness Date