COOK CLINIC

# HEALTH CARE TREATMENT AUTHORIZATION CONSENT FOR INCAPACITATED ADULTS

This form is designed for those situations where an adult is not capable of making a decision regarding proposed health care and has not appointed a health care representative under Ind. Code Section 16-36-1-7. This form gives authority to a designated adult ("Representative") to be present and give consent for health care for the incapacitated adult. Health care includes any care, treatment, service, or procedure to maintain, diagnose or treat an individual's physical or mental condition, including admission to a health care facility ("Health Care").

If in the good faith opinion of the attending physician an adult is incapable of making a decision regarding proposed Health Care and the person has not appointed a health care representative under Ind. Code Section 16-36-1-7, or the representative appointed under that Section is not reasonably available or declines to act, then consent to Health Care may be given by a judicially appointed guardian of the person. However, if there is no guardian or the guardian is not reasonably available or declines to act, or the existence of the guardian or other representative is unknown to the health care provider, then consent to Health Care may be given by: 1) a spouse, 2) a parent, 3) an adult child or 4) an adult sibling.

This form must be signed by a spouse, parent or adult child or adult sibling of the incapacitated person. It delegates authority to the person(s) named below to be present and to give consent for Health Care for the incapacitated person. **This appointment is effective for one year from the date it is signed by the person who is delegating the authority.**

**Legal Name of Incapacitated Person:** _____

**Date of Birth of Incapacitated Person:** _____

**Address of Incapacitated Person:** _____

_____

## Delegation of My Authority to Consent to Treatment of an Incapacitated Person

I, _____, the (☐ spouse), (☐ parent), (☐ adult child), (☐ adult sibling) **(check one)** of the Incapacitated Person named above, do hereby authorize the individual(s) named below ("Representatives") to consent to any Health Care for the Incapacitated Person which any Physician or Nurse Practitioner at the Cook Family Health Center, Inc. deems advisable and either provides or supervises. The Representative(s) named below may not delegate their authority to anyone else.

| | |
|---|---|
| _____ | _____ |
| Date | Signature of Spouse, Parent, Adult Child or Adult Sibling |
| Phone: | Printed name of Parent or Adult Sibling: |

(over)

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# ACCEPTANCE OF APPOINTMENT

**(1) REPRESENTATIVE**

Printed name: | Phone:

Relationship to Incapacitated Person:

**Acceptance**

I, _____, accept the authority given to me above to consent to Health Care for the Incapacitated Person. I understand that I must act in good faith and in the best interests of the Incapacitated Person.

_____ _____

Date | Signature of Representative

**Witness**

I, _____, am 18 or older. I witnessed the signature of the spouse, parent, adult child or adult sibling above, and the signature(s) of the Representative.

_____ _____

Date | Signature of Representative

**(1) REPRESENTATIVE**

Printed name: | Phone:

Relationship to Incapacitated Person:

**Acceptance**

I, _____, accept the authority given to me above to consent to Health Care for the Incapacitated Person. I understand that I must act in good faith and in the best interests of the Incapacitated Person.

_____ _____

Date | Signature of Representative

**Witness**

I, _____, am 18 or older. I witnessed the signature of the spouse, parent, adult child or adult sibling above, and the signature(s) of the Representative.

_____ _____

Date | Signature of Representative