Hawai'i Island Community Health Center

MINOR (CHILD) POWER OF ATTORNEY

Hawai'i Island Community Health Center (HICHC) requests that you complete the form on the reverse to allow another adult to bring your child (or children) to the clinic for an appointment **in the event that you are unable to do so**.

This is a state requirement that a minor cannot be seen or treated without the parent or a legal guardian present to consent except for some specific circumstances.

HICHC will require this document to be **signed by you and notarized to authorize another adult (18+ years) to bring your child, view medical records, and make any type of health care decision on behalf of your child (children).**

This document will be kept in our files and will be used to verify the identification of the adult who brings your child or children to the health center. If there is more than one person you would like to designate, please provide their names and relationships to your child (children).

We appreciate your cooperation and assistance with this requirement. We have a staff member who can notarize the document at no cost to you, so please let us know if you would like to request this service.

Hawai'i Island Community Health Center

MINOR (CHILD) POWER OF ATTORNEY

PLEASE PRINT CLEARLY

Please indicate your relationship to Patient: ☐ Mother ☐ Father ☐ Parents ☐ Legal Guardian(s)

I (or we), (print name(s)): _____

living at home address(es): _____

give rights to make parental or guardian decisions on behalf of the Minor(s) named below to the person(s) listed below as Attorney(s)-in-Fact, and grant said Attorney(s)-in-Fact powers to view medical/dental records and make any type of health care decision for my (our) child/ren.

ATTORNEY(S)-IN-FACT (List adult(s), age 18+, to whom you give the above rights on behalf of your child/ren)

Name: _____ Birthdate: _____ Relationship to Child: _____

Name: _____ Birthdate: _____ Relationship to Child: _____

Name: _____ Birthdate: _____ Relationship to Child: _____

MINOR CHILD/REN (List those who are under 18 years of age)

Name: _____ Birthdate: _____

Name: _____ Birthdate: _____

Name: _____ Birthdate: _____

Parent Signature(s): _____ **Date:** _____

Witness 1: _____ **Date:** _____

Witness 2: _____ **Date:** _____

Acceptance by Attorney-in-Fact: The undersigned Attorney-in-Fact acknowledges and executes this Power of Attorney, and by such execution does hereby affirm that I: (a) accept the appointment; (b) understand the duties under the Power of Attorney and under the law.

Attorney(s)-in-Fact: _____

STATE OF HAWAII

County of _____

On this _____ day of _____ 20____, before me personally appeared _____ to me known to be the person (or persons) described in and who executed the foregoing instrument, and acknowledged that he/she/they executed the same as his/her/their free act and deed.

Witness my hand and seal.

Notary Public Signature: _____

Notary Name: _____

Commission #/Exp Date: _____

Document Description: _____

Document Date: _____ # of Pages: _____