Valle del Sol
COMMUNITY HEALTH

Patient Surrogate/Guardian Identification Form

This form is used to identify the person(s) legally authorized to make healthcare decisions or access health information on behalf of the patient. Please complete all sections and attach supporting legal documentation (e.g., court order, power of attorney, guardianship papers).

Patient Information

Patient Name: _____ Date of Birth: ___/___/_____

Medical Record #: _____ Phone: _____

Surrogate/Guardian Information

Name: _____ Relationship to Patient: _____

Address: _____

Phone: _____ Email: _____

Legal Authority

☐ Parent

☐ Legal Guardian (attach court documentation)

☐ Healthcare Power of Attorney (attach documentation)

☐ Other (specify): _____

Scope of Authorization

☐ Consent for Medical Treatment

☐ Access to Health Information/Records

☐ Behavioral Health Treatment Decisions

☐ Other: _____

Expiration/Revocation

This authorization remains in effect until revoked in writing by the patient or until _____ (date).

Signatures

Patient (if able): _____ Date: ___/___/_____

Surrogate/Guardian: _____ Date: ___/___/_____

Staff Witness: _____ Date: ___/___/_____