MEDICAL CENTER

APPOINTED RESPONSIBILITY FOR MINOR'S CARE

I, ________________________________, father/mother/legal guardian of
(Name of Parent)

________________________________, do hereby permit ________________________________
(Name of Patient) *(Name of Appointed Representative)*

to act in my behalf in authorizing medical care for the identified patient above. I accept responsibility, financial and medical, for all decisions made by the representative I have appointed on this form. I also waive any action against McLaren relating to the medical care authorized by my appointed representative.

McLaren may rely upon this Appointment form, unless I advise office differently by written statement.

_____________________________________ _____ / _____ / _____
Signature of Parent / Legal Guardian Date

_____________________________________ _____ / _____ / _____
Signature of Appointed Representative Date

Patient Name:

Date of Birth