Patient Guardianship

Acct #

HEALTHTEXAS PROVIDER NETWORK
Affiliated with Baylor Health Care System

Only complete this form if the patient has a Legal Guardian

Guardian

Guardian Last Name	First Name	Relationship to Patient
Home Phone	Work Phone	Cell Phone

Healthcare Decision Maker

Please check the appropriate box below for the healthcare decision maker **(check one):**

☐ Mother ☐ Father ☐ Mother & Father ☐ Other: _____

Document any guardianship or custody issues below and provide supporting legal documentation.

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed on this form will require my specific authorization prior to the disclosure of any medical information

_____

Patient Name (please print)

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**