(This form may be used only if the parent or other person with medical consent rights who would be signing this form is prevented from coming to Department sites to consent and/or to participate in treatment with the minor named below, because of being housebound, incarcerated, living out of the area, or other such impediments. If the parent is physically able to come to the clinic to give consent, this form may not be used. If this form is used, an ID of the parent or other person signing that contains the person's signature, or a copy of such an ID, must accompany this form.)

I have medical consent rights regarding _____, a minor, because I am the ☐ parent ☐ legal guardian ☐ other person having legal custody (describe legal relationship_____). I am unable to come to Department sites to give consent and/or to participate in the treatment of this child because _____

_____

I hereby authorize _____ (name of person) to act as my agent to consent to mental health care for the minor named below (as permitted by law, specifically including Family Code 6910 and described in DBH SPM 811).

I understand that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but it is given to provide authority to the above-named agent to give consent to any and all such mental health treatment, or hospital care that the Department of Behavioral Health recommends.

I hereby authorize any hospital or outpatient facility providing treatment to the minor named below to physically release the minor to the above-named agent upon completion of the treatment. (This authorization is given pursuant to Health and Safety Code Section 1283.)

These authorizations shall remain effective until _____, 20___, unless sooner revoked in writing delivered to the agent named above or to DBH.

(Please complete the information on the reverse before signing.)

Signature of Parent, Guardian, or Other Person with Legal Custody Who Hereby Delegates Authority: _____ Date: _____

Signature of Person Witnessing the Above Signature: _____

Type of ID Showing Signature Confirming Delegating Signature Above: _____

DELEGATION OF TX CONSENT
SAN BERNARDINO COUNTY
DEPARTMENT OF BEHAVIORAL HEALTH
Confidential Patient Information
See W&I Code 5328

NAME:

CHART NO:

DOB:

PROGRAM:

HEALTH INFORMATION REGARDING _____

Date of Birth _____

Allergies to medications, food, etc _____

_____

Conditions for which minor is currently being treated _____

_____

_____

Current medications _____

_____

_____

Primary care M.D._____ Phone _____

Medical insurance _____

Mother's name _____ Phone _____

Address _____

Father's name _____ Phone _____

Address _____

DELEGATION OF TX CONSENT
SAN BERNARDINO COUNTY
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Confidential Patient Information
See W&I Code 5328

NAME:

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