和睦家医疗
United Family Healthcare

上海和睦家医院
Shanghai United Family Hospital
上海市长宁区平塘路699号，邮编：200335
699 Ping Tang Road, Chang Ning District, Shanghai 200335
预约中心/ Appt Center: 400 639 3900传真/ Fax : +86 21 2216 3919

病人姓名 Patient Name:
性别 Sex:
出生日期 Date of Birth:
病历号 Medical Record No.:

AUTHORIZATION FOR MINORS WHO CANNOT BE ACCOMPANIED BY A PARENT / LEGAL GUARDIAN

I am the parent/legal guardian of the above-named patient who is under 18 years of age.

I may not be able to accompany my child when he/she requires routine medical (including routine diagnostic, therapeutic procedures and medical treatment), immunization and dental services. I authorize the health care providers of the above-named facility to provide my child with routine medical, immunization and dental treatment for my child.

I further acknowledge that my child under 18 years of age must be accompanied by an adult in my absence. I will designate a proxy in writing to accompany my child for these services.

I authorize _____ (Name of adult to accompany my child) as the healthcare proxy to accept the routine medical, immunization and dental services as medically indicated. I further understand that this consent form (including the authorization) will be valid and remain in effect for a period of _____ years (or one year if not otherwise specified) from the day I sign below.

HEALTHCARE PROXY INFORMATION (must be filled in)

1. Name: _____ Valid ID: _____
   ID Number: _____
   Address: _____
   Telephone: _____ Mobile Phone: _____
2. Name: _____ Valid ID: _____
   ID Number: _____
   Address: _____
   Telephone: _____ Mobile Phone: _____

Print Name of Legal Guardian: _____

Address: _____
(Home)

_____
(Work)

Telephone Number: _____
(Home) (Work)

In general, UFH in this consent form refers to any United Family Hospitals and Clinics within United Family Healthcare in China. UFH is registered in the People's Republic of China conducting its activities in accordance with Chinese Law. I agree that any controversy, claim or dispute relating to treatment in UFH will be governed and interpreted exclusively in accordance with the law of the People's Republic of China. I also agree that all controversies, claims or disputes shall be litigated, if at all, only in the Courts of the People's Republic of China, and to the exclusion of courts of any other countries.
I have the full civil capacity. Healthcare provider has explained the contents, risks and consequences of this Consent Form to me, and answered related questions.

_____ _____
Signature of legal guardian Date YYYY/ MM/ DD Time: Hour: Min
(Place a copy of the authorizing and relationship documents in the medical record)

Witness:
There is no interest between patient and me. I have witnessed the patient or other appropriate person voluntarily signs this form.

_____ _____ _____ _____
Witness: Full name Title ID number Signature

INTERPRETER / TRANSLATOR: (To be signed by the interpreter / translator if the patient required such assistance)
To the best of my knowledge the patient understood what was interpreted / translated and signed this form voluntarily.

_____ _____ _____
Interpreter / Translator: Full name ID number Signature