Acknowledgement of Consenting Person/Surrogate Decision-Maker

Notice:

- Completing this form will acknowledge a person's consent to medical treatment of (i) a child by a non-parent as provided by Texas Family Code, Section 32.001 or (ii) an adult by a Surrogate Decision-Maker for the person receiving services from a Home and Community Support (HCS) services agency, hospital or nursing home as provided by Texas Health & Safety Code, Chapter 313.

- Services and benefits with Superior HealthPlan will not change if members do not submit this form.

- To cancel this form, send us a written request at the address on the bottom of this page. Call the Member Services number on the back of the member's ID card for help.

- Superior cannot ensure that the person or group the member allows us to share health information with will not share it with someone else.

- Members should keep a copy of all completed forms sent to Superior. Superior can provide copies if needed.

- If you need help or if you have questions about this form, please call the Member Services number on the back of the member's ID card.

- Complete this form in its entirety. When finished, mail or fax the form and any supporting documentation to:

  Superior HealthPlan
  ATTN: Compliance Department
  5900 E. Ben White Blvd.
  Austin, TX, 78741

  Fax: 1-833-205-1935

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Superior HealthPlan is committed to our members' privacy rights and interests. Superior also recognizes there are instances where friends and family support our members in their medical decisions. In an effort to balance our members' privacy interests with the need for informed consent, we offer this form to health-care providers to acknowledge a Consenting Person/Surrogate Decision-Maker.

Please complete this form to acknowledge the Consenting Person/Surrogate Decision-Maker for this individual.

1. I am a provider of health-care services for _____
   Patient Name

   DOB _____ Member ID Number or SSN_____

2. I acknowledge the following individual(s) as Consenting Person/Surrogate Decision-Maker(s) who agrees to consent for medical, dental, psychological or surgical treatments on behalf of the above-named individual.

   _____ _____
   Printed Name Signature

   _____ _____
   Printed Name Signature

3. Pursuant to: *(Both CANNOT be selected)*

   ☐ Consent to medical treatment of a child by non-parent as provided by Texas Family Code, Section 32.001 at https://statutes.capitol.texas.gov/Docs/FA/htm/FA.32.htm.

   ☐ Consent to medical treatment by a Surrogate Decision-Maker for the individual who is receiving services from a Home and Community Support (HCS) services agency, hospital or nursing home as provided by Texas Health & Safety Code, Chapter 313 at https://statutes.capitol.texas.gov/Docs/HS/htm/HS.313.htm.

4. This authorization ends on (date/event):_____
   Date this authorization ends unless canceled. If this field is blank, the authorization expires one year from the date of the signature below.

_____ _____
Signature of Health-Care Provider Date

_____
Printed Name of Health-Care Provider

PROTECTION FROM ABUSE, NEGLECT, EXPLOITATION: If a person who receives a copy of this agreement, or is aware of the existence of this agreement, has cause to believe that a child, elderly adult or adult with a disability is being abused, neglected or exploited by the Consenting Person/Surrogate, the person shall report the alleged abuse, neglect or exploitation to the Department of Family and Protective Services by calling the Abuse Hotline at 1-800-252-5400 or online at www.txabusehotline.org.

DUTY OF CERTAIN PERSONS WITH RESPECT TO AGREEMENT: A person, who receives the original, or a copy of a surrogate decision-making agreement, shall rely on the agreement. A person is not subject to criminal or civil liability, and has not engaged in professional misconduct for an act or omission, if the act or omission is in good faith, and in reliance on a surrogate decision-making agreement.