OCFS-4940 (06/2018)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

DESIGNATION OF PERSON IN PARENTAL RELATIONSHIP

Pursuant to section 5-1551 of the New York State General Obligations Law.

1. I, _____ , hereby state that I am the parent of the child/children/incapacitated person(s) named below and there are no court orders now in effect in any jurisdiction that would prohibit me from exercising the power that I now seek to authorize.

2. The address and telephone number(s) where I can be reached while this designation is in effect is:

Address: _____

_____

Telephone: Home ( ) Work ( )

Other ( ) _____

3. I am temporarily entrusting _____ , a person over the age of eighteen who resides at _____ _____ New York, _____ telephone number ( ) the care of the following child/children/incapacitated person(s):

NAME:	DATE OF BIRTH:
NAME:	DATE OF BIRTH:
NAME:	DATE OF BIRTH:
NAME:	DATE OF BIRTH:

4. Any authority granted to the person in parental relationship pursuant to this form shall be valid (check appropriate box and initial):

☐ _____ a. for 12 months from the date of signature of this designation, or until the date of revocation, whichever occurs first (must include all parties' addresses and telephone numbers and be signed by all parties in the presence of a notary public); or

☐ _____ b. for 30 days from the date of signature of this designation, or until the date of revocation, whichever occurs first; or

☐ _____ c. from __/__/____ (date) until and including __/__/____ (date), or until the date of revocation, whichever occurs first; or

☒ _____ d. commencing upon my arrest, detention, deportation or removal from the United States (state event) and continuing until 12 months from this event or until the date of revocation, whichever occurs first.

5. As to the above named child/children/incapacitated person(s), the person in parental relationship named above is authorized to:
(check those that apply)

☐ review school records

☐ enroll in school

☐ excuse absences from school

☐ consent to participation in school program and/or school-sponsored activity

☐ consent to school-related medical care*

☐ enroll in health plans

☐ consent to immunizations*

☐ consent to general health care*

☐ consent to medical procedures*

☐ consent to dental care

☐ consent to developmental screening

☐ consent to mental health examination and/or treatment

* Except as prohibited by Section 2504 of the Public Health Law

Any of the above authorizations may be further limited by conditions defined by the parent, and, if limited, the limitations are written below (e.g., the parent may grant the authority to consent to a mental health examination, subject to the condition that they cannot be reached by telephone or other electronic means).

6. I further authorize the person in parental relationship to request, receive and review, and be granted full and unlimited access to, and obtain complete unredacted copies of any and all of health, medical, financial information and/or any information and/or records as defined in 45 CFR. §164.501 and regulated by the Standards for Privacy of Individually Identifiable Health Information found in 65 Fed. Reg. 82462 as protected private records or otherwise covered under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, for each child/incapacitated person listed in paragraph 3 above. I understand that the information contained in such health and medical records may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), AIDS-related complex (ARC) and human immunodeficiency virus (HIV), behavioral or mental health services, treatment for alcohol and/or drug abuse and/or addiction. I further understand that I may have access to and/or receive an accounting of the information to be used or disclosed as provided in 45 CFR §164.524, et seq. I further understand that authorizing the disclosure of this health information is voluntary; that I can refuse to sign this authorization. I further understand that any disclosure of this information carries with it the potential for an unauthorized further disclosure of this information by third parties and that such further disclosure may not be protected under HIPAA. In order to induce the disclosing party to disclose the aforesaid private and/or protected confidential information, I forever release and hold harmless said disclosing party who relies upon this instrument from any liability under confidentiality rules arising under HIPAA as a consequence of said disclosure.

7. NOTICE TO PARENTS AND PERSONS IN PARENTAL RELATION: Authorization pursuant to this form is valid until the earlier of revocation by a parent or the date specified in paragraph 4 above. Any parent having signed this designation may revoke such authorization at will, and may notify relevant schools and health care providers of such revocation. A person in parental relationship who receives notification from a parent of such revocation shall forthwith notify any school, health care provider or health plan to which an authorization pursuant to this subdivision has been presented. Failure by the person in parental relation to notify recipients of the authorization or the revocation shall not make notification of revocation by the parent ineffective.

This authorization is temporary, but may be renewed by the parent(s). However, parents and persons in parental relationship involved in a long-term, care-giving arrangement may seek a more permanent legal arrangement by commencing a judicial proceeding to appoint legal guardianship or to determine custody.

Note: All signatures below must be notarized if authorization is for a period exceeding 30 days.

Dated: / / (Parent's signature) _____

Sworn to before me this

_____ day of _____ 20 _____

Notary Public _____

8. I, _____, am also the parent of the child/children/incapacitated person(s) named herein, there is a court order directing that both parents must agree on education and/or health decisions concerning such child/children/incapacitated person(s), and I hereby consent to this designation by my signature below.

The address and telephone number(s) where I can be reached while this designation is in effect is:

Address: _____

Telephone: Home ( ) - Work: ( ) -

Other: ( ) -

Dated: / / (Parent's signature) _____

Sworn to before me this

_____ day of _____ 20 _____

Notary Public _____

9. I, _____ , the person designated in parental relationship for the child/children/incapacitated person(s) named herein, hereby consent to this designation by my signature below.

Dated: ___/___/_____ Signature _____

Sworn to before me this

_____ day of _____ 20 _____

Notary Public _____

Instructions for DESIGNATION OF PERSON IN PARENTAL RELATIONSHIP, pursuant to section 5-1551 of the New York State General Obligations Law.

PURPOSE OF THIS FORM:

This form will allow you to designate another person to make medical and educational decisions for your child(ren) or incapacitated person(s) in your care if you can't do so yourself for a specific period of time. This authorization can only be used for a period of up to 12 months. If you will need to have your child(ren)/incapacitated person(s) in the care of someone else for more than 12 months, you may wish to consider other options.

If there is a court order that requires both parents to agree on education and/or health decisions regarding the child(ren), then both parents must sign the form. If not, only one parent's signature is required.

You keep all of your parental rights with this authorization and can cancel (revoke) this authorization at any time. The person you designate will be able to talk with your child(ren)'s school, teachers and medical providers, and will be able to make routine decisions. The person you designate will not be able to give consent for surgery or other major medical procedures but will be able give consent for routine medical matters. If you do not want the person you designate to be able to make certain decisions, such as decisions concerning immunizations, you can specify that with this form. If the person you designate makes a decision concerning your child(ren)/incapacitated person(s) that you do not agree with, you can override that decision.

The person designated must agree to be "a person in parental authority," and will not be required to assume responsibility for financial support of the child(ren)/incapacitated person(s). Your child(ren) will not have to change their school district if that person resides in another school district. In the event of your death or incapacitation, this designation automatically terminates.

INSTRUCTIONS FOR USING THIS FORM:

Paragraph 1: Fill in your full legal name in the space provided. If there is a court order in effect that requires both parents to sign, the other parent will fill in their name in the space provided in Paragraph 7.

Paragraph 2: Fill in your address and telephone number(s). If this information is not included, the authorization will not be valid for more than 30 days. Use the address where you will be staying during the period this authorization is in effect, even if it is not your legal residence. For example, if this authorization is to be used while you are hospitalized, you would use the hospital's address.

Paragraph 3: Fill in the name, address, and telephone number of the person whom you wish to designate as able to make educational and/or health decisions for your child(ren)/incapacitated person(s). Fill in the name(s) and date(s) of birth for EACH child/incapacitated person.

Paragraph 4: Specify how long you wish this authorization to be in effect by checking the appropriate box and initialing next to it. Remember, you can always revoke (cancel) this designation sooner if you wish. Information about how to do that is included toward the end of these instructions.

- **Use (a)** if you want this designation to be valid for 12 months. If you choose this option, you must provide the address and telephone number for the parent(s) and the other person, and all the signatures must be notarized.

- **Use (b)** if you want this designation to be valid for 30 days. You do not have to include addresses and telephone numbers with this choice, but it is suggested that you do so in the event that medical or educational care providers need to contact you.

- **Use (c)** if you want to use specific dates, for a period of less than or more than 30 days. Remember, this designation cannot be used for more than 12 months, and you must include addresses, telephone numbers, and notarized signatures if you want it to be good for more than 30 days.

- **Use (d)** if you want this designation to begin when something specific, such as in the event you are hospitalized. For this, you write the specific event in the first space provided (example: “When I am admitted to a hospital”) and write the date or the event upon which the designation should expire in the second space (example: “30 days later” or “when I am released from the hospital”). Again, you must include addresses, telephone numbers, and notarized signatures if you want it to be good for more than 30 days.

Paragraph 5: List each of the things you wish the person you designate to be able to do. Cross out and initial EACH item that you do NOT wish to allow the person you designate to perform. If there are other things you want to prevent the person from doing, use the blank lines below the list to write those down. For example, if you want to be contacted before any mental health examination is performed, you can write that in the space provided.

Paragraph 6: This paragraph allows the person you designated to have access to your child(ren)’s/incapacitated person(s)’ medical records and medical information.

Paragraph 7: This provides some information regarding this form. The parent whose name appears in Paragraph 1 then signs and dates the form. If this authorization is to be in effect for a period of more than 30 days, the signature must be notarized. In this case, you need to take the form to a notary public before you sign it, and sign the form in front of that notary public, who will then also sign the form to indicate that they witnessed your signature. If don’t do this, the authorization will automatically expire after 30 days.

Paragraph 8: If there is a court order in effect that requires both parents to agree on education and/or health decisions regarding the child(ren), then the other parent will fill in their full legal name, address, and telephone number in the spaces provided. As with the first parent, they do not have to provide their address and telephone number if the authorization is for a period of 30 days or less, but may wish to. They must provide this information, and sign the form in front of a notary public, if the authorization is to be good for more than 30 days. If there is no court order in effect that requires both parents to agree, you can leave this paragraph blank.

Paragraph 9: Fill in the full legal name of the person to be designated “in parental relationship” to the child(ren)/incapacitated person(s). They then sign and date the form, to show that they agree to be a person in parental relationship. If this authorization is to be good for more than 30 days, they will also need to sign the form in front of a notary public.

OTHER INFORMATION:

- Major medical treatment: The person you designate **CANNOT** give consent for "major medical treatment" which is any medical, surgical, or diagnostic intervention or procedure where a general anesthetic is used or which involves any significant risk or any significant invasion of bodily integrity requiring an incision or producing substantial pain, discomfort, debilitation, or having a significant recovery period. This does not include: any routine diagnosis or treatment such as the administration of medications other than chemotherapy for non-psychiatric conditions or nutrition or the extraction of bodily fluids for analysis; electroconvulsive therapy; dental care performed with a local anesthetic; any procedures which are provided under emergency circumstances, pursuant to section twenty-five hundred four of the public health law; the withdrawal or discontinuance of medical treatment which is sustaining life functions; or sterilization or the termination of a pregnancy.

For example, the person designated can give consent for a child/incapacitated person to have standard dental procedures, such as fillings, but not dental surgery where they would be unconscious during the procedure, such as having their wisdom teeth extracted. A parent's consent will still be required for major medical procedures.

- Revoking this designation: In order to revoke (cancel) the authorization, you simply have to tell the person you designated that you wish to do so, and they are required to notify the appropriate education and medical providers that the authorization has been terminated. While the parent is not required to do this in writing, or to notify the child(ren)/incapacitated person(s) education and medical providers that they have revoked the authorization, they may want to, so that there is no confusion. If two parents signed the form, either parent can cancel the designation by themselves, you do not need both parents.