AUTHORIZATION FOR RELEASE OF INFANT/CHILD TO OTHER THAN PARENT/LEGAL GUARDIAN

Purpose:

To provide a mechanism for authorization for release of an infant/child to anyone other than the parent or legal guardian.

Policy:

It is the policy of LSU Health Sciences Center in Shreveport that:

1. No infant/child shall be released to anyone other than the parent/legal guardian without authorization.

2. All pediatric/adolescent patients shall be screened on admission by a Registered Nurse for any potential custody/security issues related to their care.

3. Custody/security issues will be noted on the Patient History/Assessment and Discharge Record (SN 1048) and an authorization for release of infant/child to other than parent/legal guardian form will be placed on the front of the medical record.

4. The authorization for release must be signed by parent or legal guardian and witnessed by two LSUHSC employees prior to discharge of infant/child to anyone other than the parent/legal guardian.

5. Proof of identification must be provided by the person designated by the parent or legal guardian before the child is released to their care. Examples of identification may include: Drivers license or other type of photo ID.

6. Should there be any question regarding legal guardianship of an infant/child staff shall contact the Administrator on Call for direction prior to proceeding with discharge.

_______________________
Administrator

9/23/10
Date

Approved by Clinical Board: 5/15/01, 7/20/04, 6/19/07, 9/21/10
Written: 04/01
Reviewed: 6/04, 5/07, 8/10
Revised: 6/04, 5/07, 8/10 (form only)
AUTHORIZATION FOR RELEASE OF INFANT/CHILD TO OTHER THAN PARENT/LEGAL GUARDIAN

I, ___________________________, do hereby grant my permission for my child, ___________________________, ______________________, to be released to:

Name                                          DOB
________________________, _________________

Name                                                               Relationship

This release does not constitute an adoption or change in custody.

The child will be physically located at the following address:
________________________________________
________________________________________
________________________________________
(Phone)________________________

I agree that LSU Health Sciences Center – Shreveport is released from any liability in this release. I am signing this form of my own free will.

__________________________                                ____________________
Mother’s Signature                                      or                                      Father’s Signature

________________________
Date

Witnesses:
________________________________________
________________________________________
________________________________________