Community Resource Center Immigration Clinic March 19, 2017

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I. Designation of Person in Parental Relationship

- A parent may sign this form to name someone to serve as temporary guardian of children in the event a parent is unable to care for the children.
- If a parent signs this form, her or she should keep the original with other important papers.
- The parent should also give a copy of this form to the person named in the document as the temporary guardian.
- The temporary guardian should be told where the original document is located in case something happens to the parent.

Concerns:

- If the parent is divorced it is likely there is already a child custody order in place and only the parent with custody can sign this form.
- Both parents must agree on the guardian. Otherwise, the form will not be honored.
- A court is not required to honor the form although it is a factor the court will consider when determining the children's best interests.
- If parents have never been married and they have not executed an Acknowledgement of Paternity nor has a court entered an Order of Filiation stating only the mother is required to complete the form. (However, it is wiser to have the putative father agree with the mother to avoid future problems.)

Limitations:

- The form can last no longer than six months from the date it is signed and must be re-executed every six months to continue to be effective.
- The form can be overturned by Court Order if it is determined that the proposed guardian does not meet the best interests of the child.
- The form can be nullified if both parents do not agree about the guardian.
- The form does not enable a guardian to enroll children in new schools, they must remain at their current schools.

II. Authorization for Release of Health Information Pursuant to HIPPA

- The HIPPA form enables health care providers and organizations, as well as their business associates to share confidential and secure health information with specified individuals.

III. U.S. Department of State - Statement of Consent: Issuance of a US Passport to a Minor Under Age 16

- The purpose of this form is to explain to the U.S. Passport officials why a child's parents did not apply for the passport.
- Otherwise, a passport for a minor child must be submitted at a U,.S. Post Office by both parents of the minor child. The only exceptions are (i) if there is only one parent named on the child's birth certificate, (ii) if there is a court order granting sole legal and physical custody to one parent, or (iii) if the parent has completed the above referenced form.

IV. Power of Attorney

This is a useful toll for a person to settle his/her affairs before being deported (For example, sell a house, end a rental agreement, access a safe deposit box).

The person executing the PofA is the principal. The person to whom the power is given is the agent.

The PofA gives one person the legal right to act on behalf of another.

The principal should select someone he/she trusts who can remain in the U.S. to take care of matters for you as your agent.

The agent must be over the age of 18;has the necessary documentation to be in the U.S. legally, can be trusted to act wisely and in accordance with the principal's wishes, is willing to spend the time and effort necessary to manage the principal's finances, is comfortable dealing with banks and has a basic understanding of financial issues and resides in the same state as the principal.

The PofA gives one person the legal right to act on behalf of another.

Checklist:

- Execute a Designation of Person in Parental Relationship for each child;
- Execute a HIPPA Release for each child;
- Obtain copies of your children's passports: travel.state.gov/passport/get/minors/minors.834 or execute a U.S. Department of State Statement of Consent;
- Execute a Power of Attorney;
- Obtain copies of your children's birth certificates from the state in which the child was born: www.cdc.gov/nchs/howto/w2w/w2welcom.
- Obtain copies of your children's social security cards: www.socialsecurity.gov/online/SS-5.htm.
- Make copies of any custody orders or agreements or Judgments of Divorce.
- Make copies of any other court orders, such as Orders of Protection or anything having to do with the children.
- Tell someone you trust where these documents are so that they can find them if necessary and make sure that they know where the documents are kept and have access to them.

OCFS-4940 (2/2010)

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 six months days 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 thirty 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 _____ (state event) and continuing until _____, 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:
(cross out and initial any that do not apply)

a. review school records;

b. enroll in school;

c. excuse absences from school;

d. consent to participation in school program and/or school-sponsored activity;

e. consent to school-related medical care;*

f. enroll in health plans;

g. consent to immunizations;*

h. consent to general health care;*

i. consent to medical procedures;*

j. consent to dental care;

k. consent to developmental screening; and/or

l. 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 relation 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 relation 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 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 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 six months. If you will need to have your child(ren)/incapacitated person(s) in the care of someone else for more than six 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 thirty 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 six 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 thirty 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 thirty days. Remember, this designation cannot be used for more than six months, and you must include addresses, telephone numbers, and notarized signatures if you want it to be good for more than thirty 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: "thirty 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 thirty 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 thirty 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 thirty 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 thirty 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 thirty 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 thirty 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.

OCFS-4940S (2/2010)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

DESIGNACIÓN DE UNA PERSONA EN UNA RELACIÓN PATERNAL/MATERNAL

De acuerdo con la Sección 5-1551 de la Ley de Obligaciones Generales del Estado de Nueva York
(*New York State General Obligations Law*)

1. Yo, _____, por la presente declaro que soy el padre/madre del niño(a)/niños(as)/persona(s) discapacitada(s) mencionada(s) a continuación y que no existe hasta la fecha una Orden Judicial en vigencia en ninguna jurisdicción que me prohíba ejercer la autoridad que ahora exijo ejercer.

2. El domicilio y el/los número(s) de teléfono(s) donde se me puede ubicar mientras esta designación esté en vigencia es/son:

Domicilio: _____

_____

Teléfono: Particular ( ) _____; Trabajo ( ) _____

(Otro) _____

3. Temporalmente otorgo a _____, persona mayor de dieciocho años de edad que reside en _____, _____, Nueva York, número de teléfono ( ) _____, el cuidado del siguiente niño(a)/niños(as)/persona(s) discapacitada(s):

_____{NOMBRE} fecha de nacimiento _____

_____{NOMBRE} fecha de nacimiento _____

_____{NOMBRE} fecha de nacimiento _____

_____{NOMBRE} fecha de nacimiento _____

4. Toda autoridad otorgada a la persona en una relación paternal/maternal en virtud de este formulario tendrá validez (marque la casilla apropiada y coloque sus iniciales):

☐ _____ a. durante seis meses desde la fecha de la firma de esta designación o hasta la fecha de la revocación, lo que ocurra primero (debe incluir los domicilios y los números de teléfono de todas las partes, y todas las partes deben firmar ante la presencia de un notario público); o

☐ _____ b. durante treinta días desde la fecha de la firma de esta designación o hasta la fecha de la revocación, lo que ocurra primero; o

☐ _____ c. desde _____(fecha) hasta e inclusive_____(fecha) o hasta la fecha de la revocación, lo que ocurra primero; o

☐ _____ d. a partir de _____

(indique el evento) y continuará hasta_____ o hasta la fecha de la revocación, lo que ocurra primero.

5. En lo que respecta al niño(a)/niños(s)/persona(s) discapacitada(s) mencionada(s) previamente, la persona designada en una relación paternal/maternal tiene la autoridad para: (tache y coloque sus iniciales en cualquier apartado que no corresponda)

a. revisar los registros escolares;

b. realizar inscripciones en la escuela;

c. excusar inasistencias escolares;

d. autorizar la participación en programas escolares y/o actividades patrocinadas por la escuela;

e. autorizar la atención médica relacionada con la escuela*;

f. realizar inscripciones en planes médicos;

g. autorizar inmunizaciones*;

h. autorizar la atención médica general*;

i. autorizar procedimientos médicos*;

j. autorizar la atención dental;

k. autorizar evaluaciones de desarrollo; y/o

l. autorizar un examen de salud mental y/o tratamiento

*Excepto lo que se prohíba de acuerdo con la Sección 2504 de la Ley de Salud Pública.

Cualquiera de las autorizaciones previas puede estar sujeta a limitaciones adicionales, conforme a condiciones estipuladas por el padre/madre, y, en caso de limitarse la autoridad, las limitaciones se indicarán a continuación (por ej. el padre/madre puede otorgar la autorización para un examen de salud mental, sujeto a la condición de que no se le contacte por teléfono o por otros medios electrónicos).

_____

_____

_____

6. Además, yo autorizo a la persona en una relación paternal/maternal a solicitar, recibir y revisar, y a tener acceso pleno e ilimitado, y a obtener copias completas no redactadas de todo y cualesquiera información de salud, médica, financiera y/o cualesquiera información y/o registros según se define en 45 CFR. § 164.501 y regulado por los Estándares de Privacidad de la Información Médica Identificable Individualmente (*Standards for Privacy of Individually Identifiable Health Information*) que aparece en la Reg. Fed. 65 82462 como registros privados protegidos o de otro modo cubiertos bajo la Ley de Portabilidad y Responsabilidad de Seguro Médico de 1996 (*Health Insurance Portability and Accountability Act—HIPAA*), Ley Pública 104-191, por cada niño(a)/persona discapacitada enumerada en el párrafo 3 precedente. Entiendo que la información que aparece en dichos registros médicos y de salud puede incluir información pertinente a enfermedades de transmisión sexual, síndrome de inmunodeficiencia adquirida (SIDA), complejo relacionado con el SIDA (ARC) y el virus de inmunodeficiencia humano (VIH), servicios por trastornos de conducta o salud mental, tratamiento por alcoholismo y/o abuso de drogas y/o adicción. Asimismo entiendo que puedo tener acceso a y/o recibir una reseña de la información a ser utilizada o divulgada según se dispone en 45 CFR § 164.524, et seq. Asimismo entiendo que autorizar la divulgación de esta información médica es un acto voluntario, y que puedo rehusarme a firmar esta autorización. Asimismo entiendo que cualquier divulgación de esta información conlleva el potencial de una divulgación no autorizada de esta información por parte de terceros, y que dicha divulgación puede no estar protegida bajo la HIPAA. A fin de inducir a la parte reveladora a divulgar la información privada y/o confidencial previamente mencionada, eximo o excuso para siempre a dicha parte reveladora, quien se basa en este instrumento, de cualesquiera responsabilidad u obligación que pudiera surgir en virtud del reglamento de confidencialidad conforme a la HIPAA a causa de dicha divulgación.

7. NOTIFICACIÓN A LOS PADRES Y PERSONAS EN UNA RELACIÓN PATERNAL/ MATERNAL: La autorización de acuerdo con este formulario es válida hasta lo que ocurra primero: la revocación por parte del padre/madre o la fecha especificada en el párrafo 4 precedente. El padre/madre que firmó esta designación podrá revocarla a voluntad, y podrá notificar a las escuelas pertinentes y a los proveedores de atención médica sobre dicha revocación. Una persona en una relación paternal/maternal que reciba notificación de un padre/madre sobre tal revocación deberá notificar a las escuelas, a los proveedores de atención médica o a los planes médicos ante quienes se presentó una autorización en virtud de esta subdivisión. En la eventualidad de que la persona en una relación paternal/maternal no notifique a los destinatarios sobre la autorización o la revocación, esto no anulará la efectividad de la notificación de revocación por parte de los padres.

Esta autorización es temporal, pero puede ser renovada por los padres. No obstante, los padres y las personas en una relación paternal/maternal involucrados en un acuerdo de cuidado a largo plazo pueden procurar un acuerdo legal más permanente iniciando un procedimiento judicial para designar un tutor(a) legal o determinar la custodia.

Nota: Todas las firmas a continuación se deben autenticar si la autorización es por un período que excede los 30 días

Fechado:

(Firma del padre/madre)_____

Juramentado ante mí este

___ día de _____ 20___.

_____
Notario Público

8. Yo, _____, soy también el padre/madre del niño(a)/niños(as)/persona(s) discapacitada(s) mencionada(s) en la presente, reconozco que existe también una Orden Judicial que indica que ambos padres deben estar de acuerdo con las decisiones sobre la educación y/o la salud relacionadas con dicho niño(s)/niños(as)/persona(s) discapacitada(s) y por la presente acepto esta designación mediante mi firma que estampo a continuación.

El domicilio y el/los número(s) de teléfono(s) en los que se me puede ubicar mientras esta designación esté en vigencia es/son:

Domicilio: _____

_____

Teléfono: Particular ( )_____; Trabajo ( ) _____

Otro ( ) _____

Fechado:

(Firma del padre/madre) _____

Juramentado ante mí este

___ día de _____ 20___.

_____
Notario Público

9. Yo, _____, la persona designada en una relación paternal/maternal para el niño(a)/niños(as)/persona(s) discapacitada(s) mencionadas en el presente formulario, acepto esta designación mediante mi firma que estampo a continuación.

Fechado:

(Firma) _____

Juramentado ante mí

___ día de _____ 20___.

_____
Notario Público

Instrucciones para la DESIGNACIÓN DE UNA PERSONA EN UNA RELACIÓN PATERNAL/MATERNAL, de acuerdo con la Sección 5-1551 de la Ley de Obligaciones Generales del Estado de Nueva York (*New York State General Obligations Law*).

OBJETIVO DE ESTE FORMULARIO:

Este formulario le permite designar a otra persona para que tome decisiones médicas y educacionales para su hijo(a)/hijos(as) o persona(s) discapacitada(s) bajo su cuidado si usted no puede hacerlo por sí mismo(a) durante un período de tiempo específico. Esta autorización sólo se puede usar por un período de hasta seis meses. Si usted necesita que su hijo(a)/hijos(as)/persona(s) discapacitada(s) estén bajo el cuidado de otra persona durante más de seis meses, quizás desee considerar otras opciones.

Si existe una Orden Judicial que exija que ambos padres estén de acuerdo con respecto a las decisiones sobre educación y/o salud de sus hijos, entonces ambos padres deben firmar este formulario. En caso contrario, sólo se requiere la firma del padre/madre.

Usted conserva todos sus derechos paternales/maternales con esta autorización, y puede cancelar (revocar) esta autorización en cualquier momento. La persona que usted designe tendrá la autoridad para hablar con el personal de la escuela que atienda a su(s) hijo(s), maestros y proveedores de atención médica y podrá tomar decisiones de rutina. La persona que usted designe no podrá autorizar una cirugía u otro procedimiento médico importante, pero podrá autorizar asuntos médicos de rutina. Si usted no quiere que la persona que designe esté autorizada para tomar ciertas decisiones, como por ejemplo decisiones sobre vacunación, puede especificarlo en el formulario. Si la persona que usted designe toma una decisión con respecto a su hijo(a)/hijos(as)/persona(s) discapacitada(s) con la que usted no está de acuerdo, puede anular dicha decisión.

La persona que usted designe debe aceptar ser una "persona con autoridad paternal/maternal", y no estará obligada a asumir responsabilidad por la manutención financiera del niño(a)/niños(as)/persona(s) discapacitada(s). Su hijo(a)/hijos(as) no tendrá(n) que cambiar de distrito escolar si esa persona reside en otro distrito escolar. En la eventualidad de su muerte o discapacidad, esta designación terminará automáticamente.

INSTRUCCIONES PARA EL USO DE ESTE FORMULARIO:

Párrafo 1: Escriba su nombre legal completo en el espacio provisto. Si existe una Orden Judicial en vigencia que exige que ambos padres firmen, el otro padre/madre escribirá su nombre en el espacio provisto en el Párrafo 7.

Párrafo 2: Escriba su domicilio y número(s) de teléfono. En caso de no incluirse esta información, la autorización no tendrá validez por más de treinta días. Escriba el domicilio donde vivirá durante el período en que esté vigente esta autorización, aunque no sea su domicilio legal. Por ejemplo, si esta autorización se utilizará durante su hospitalización, debe escribir el domicilio del hospital.

Párrafo 3: Escriba el nombre, el domicilio y el número de teléfono de la persona a quien desea designar para que tome decisiones educacionales y/o de salud para su hijo(s)/persona(s) discapacitada(s). Escriba el/los nombre(s) y la(s) fecha(s) de nacimiento para CADA niño(a)/persona discapacitada.

Párrafo 4: Especifique durante cuánto tiempo quiere que esta autorización esté en vigencia marcando la casilla correspondiente y colocando sus iniciales al lado. Recuerde, puede revocar (cancelar) esta designación antes de esa fecha si así lo desea. Al final de estas instrucciones se incluye información sobre cómo hacerlo.

- **Use (a)** si quiere que esta designación tenga validez por seis meses. Si elige esta opción, debe indicar el domicilio y el número de teléfono del padre/madre y la otra persona, y todas las firmas deben estar autenticadas.
- **Use (b)** si quiere que esta designación tenga validez por treinta días. No es necesario que incluya los domicilios y los números de teléfono con esta opción, pero le sugerimos que lo haga en caso de que los proveedores médicos o educacionales necesiten ponerse en contacto con usted.
- **Use (c)** si quiere usar fechas específicas, por un período de menos o más de treinta días. Recuerde, esta designación no se puede usar por más de seis meses, y debe incluir los domicilios, los números de teléfono y las firmas autenticadas si quiere que tenga validez por más de treinta días.
- **Use (d)** si quiere que esta designación comience con un evento específico, como por ejemplo si usted es hospitalizado(a). En tal caso, debe escribir el evento específico en el espacio en blanco provisto (ejemplo: "Cuando sea admitido(a) en un hospital") y escribir la fecha o el evento cuando venza la designación en el segundo espacio (ejemplo: "treinta días más tarde" o "cuando sea dado(a) de alta del hospital"). Nuevamente, debe incluir los domicilios, los números de teléfono y las firmas autenticadas si quiere que la designación tenga validez por más de treinta días.

Párrafo 5: Enumere las cosas que desea que la persona que usted designe tenga autoridad para hacer. Tache y coloque sus iniciales en CADA inciso para indicar que la persona designada NO tiene autoridad para hacerlo. Si hay otras cosas que quiere impedir que la persona haga, enumérelas en los renglones en blanco que aparecen debajo de la lista. Por ejemplo, si quiere que se comuniquen con usted antes de la realización de cualquier examen de salud mental, puede especificarlo en el espacio provisto.

Párrafo 6: Este párrafo permite que la persona que usted designe tenga acceso al historial clínico e información médica de su hijo(a)/hijos(as)/persona(s) discapacitada(s).

Párrafo 7: Aquí encontrará cierta información sobre este formulario. El padre/madre cuyo nombre aparece en el Párrafo 1 luego firma y fecha el formulario. Si esta autorización estará en vigencia por un período de más de treinta días, la firma debe ser autenticada. En este caso, debe llevar el formulario a un notario público antes de firmarlo, y firmar el formulario ante ese notario público, que a su vez también firmará el formulario para indicar que ha sido testigo de su firma. Si no lo hace, esta autorización vencerá automáticamente en treinta días.

Párrafo 8: Si existe una Orden Judicial en vigencia que exije que ambos padres estén de acuerdo con respecto a las decisiones sobre la educación y/o la salud de sus hijos, entonces el otro padre/madre escribirá su nombre legal completo, domicilio y número de teléfono en los espacios provistos. Al igual que el primer padre/madre, no es necesario que indique su domicilio y número de teléfono si la autorización es por un período de treinta días o menos, pero quizás desee hacerlo. Se debe proporcionar esta información y firmar el formulario ante un notario público, si la autorización estará en vigencia por más de treinta días. Si no existe una Orden Judicial en vigencia que exija que ambos padres estén de acuerdo, puede dejar este párrafo en blanco.

Párrafo 9: Escriba el nombre legal completo de la persona que será designada "en una relación paternal/maternal" con el niño(a)/niños(as)/persona(s) discapacitada(s). Luego la persona debe firmar y fechar el formulario, para mostrar que acepta ser una persona en una relación paternal/maternal. Si esta autorización estará vigente por más de treinta días, también se tendrá que firmar ante un notario público.

OTRA INFORMACIÓN:

- Tratamiento médico importante: La persona que usted designe **NO PUEDE** autorizar un "Tratamiento médico importante", lo que se refiere a cualquier intervención o procedimiento médico, quirúrgico o de diagnóstico en el que se utilice anestesia general o que conlleve un riesgo significativo o cualquier invasión considerable de la integridad corporal que requiera una incisión o produzca dolor significativo, molestias, debilitamiento o tenga un período de recuperación prolongado. Esto no incluye: cualquier diagnóstico o tratamiento de rutina como por ejemplo la administración de medicamentos a excepción de quimioterapia para condiciones no psiquiátricas o nutrición o la extracción de fluidos corporales para ser analizados; terapia electro-convulsiva; atención dental con anestesia local; cualquier procedimiento que se realice a causa de una emergencia, en virtud de la sección dos mil quinientos cuatro de la ley de salud pública; la cancelación o interrupción de un tratamiento médico que mantiene las funciones vitales; o la esterilización o la terminación de un embarazo.

Por ejemplo, la persona designada puede autorizar que un niño(a)/persona discapacitada reciba un tratamiento dental estándar, como por ejemplo el empaste de caries, pero no una cirugía dental en la que la persona estará inconsciente durante el procedimiento, tal como en una extracción de la muela de juicio. Se requerirá el consentimiento del padre/madre para los procedimientos médicos importantes.

- Revocación de esta designación: A fin de revocar (cancelar) esta autorización, sólo tiene que informarle a la persona que designó que desea hacerlo, y él/ella debería notificar a los proveedores educacionales y médicos correspondientes que la autorización ha sido cancelada. Si bien no es necesario que el padre/madre haga la revocación por escrito, o notifique a los proveedores médicos y educacionales del niño(s)/persona(s) discapacitada(s) que ha revocado la autorización, quizás prefiera hacerlo para evitar cualquier tipo de confusión. Si ambos padres firmaron el formulario, tanto el padre como la madre puede cancelar la designación; es decir, no es necesario que ambos padres lo hagan.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Date of Birth	Medical Record Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT,** except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol, or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- □ Medical Record form (insert date) _____ to (insert date) _____
- □ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- □ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**
_____ **Genetic Testing**

Authorization to Discuss Health Information

(b). □ By initialing here _____ I authorize _____
Initials Name of individual health care provider
to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm or Governmental Agency Name)

10. Reason for release of information: □ At request of individual □ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All Items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____
Signature of Patient or representative authorized by law.

*** Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

AUTORIZACIÓN PARA LA REVELACIÓN DE LA INFORMACIÓN DE SALUD CONFORME CON LA LEY HIPAA

Nombre del paciente	Fecha de nacimiento	Numero del Expediente
Dirección del paciente		

Yo, o mi representante autorizado, solicito(a) que la información de salud con respect a mi cuidado y tratamiento se revele según se establece en este formulario:

De acuerdo con las Leyes del Estado de Nueva York y las Normas de Privacidad de la Ley de responsabilidad y transferibilidad de seguros médicos (Health Insurance Portability and Accountability Act-HIPAA) de 1996, comprendo que:

1. Esta autorización puede incluir la revelación de información relacionada con el **USO EXCESIVO DE ALCOHOL Y CONSUMO DE DROGRAS, TRATAMIENTO PARA LA SALUD MENTAL**, except las anotaciones de psicoterapia y la **INFORMACIÓN CONFIDENCIAL RELACIONADA CON EL VIH*** solo si escribo mis iniciales en la línea correspondiente en el punto número 9(a). En el caso de que la información de salud descrita a continuación incluya a cualquiera de estos tips de información, y yo escriba mis iniciales en la línea de la casilla número 9(a), autorizo específicamente a revelar tal informaciόn a la(s) persona(s) indicada(s) en el punto 8.
2. Si autorizo a revelar información relacionada con el VIH, tratamiento contra el alcoholism o las drogas o tratamiento para la salud mental, se le prohíbe a la persona que recibe la información volver a revelar tal información sin mi autorización a menos que las leyes federales o estatales asi lo permitan. Comprendo que tengo derecho a solicitor una lista de personas que puedan recibir o usar mi información relacionada con el VIH sin autorización. Si experiment discriminación debido a la revelación de información relacionada con el VIH, puedo comunicarme con la División de Derechos Humannos del Estado de Nueva York (New York Division of Human Rights) en el (212) 480-2493 o con la Comisión de Derechos Humanos de la Cuidad de Nueva York (New York City Commission of Human Rights) en el (212) 306-7450. Estas agencias son responsables de proteger mis derechos.
3. Tengo derecho a revocar (cancelar) esta autorización en cualquier momento escribiendo al proveedor de cuidados de salud mencionado abajo. Comprendo que puedo revocar esta autorización except en la medida que ya se haya realizado alguna acción basada en esta autorización.
4. Comprendo que esta autorización se firma voluntariamente. Mi tratamiento, pago, inscripción en un plan de salud o elegibilidad en cuanto a los beneficios no dependerá de mi autorización a esta revelación.
5. La información revelada bajo esta autorización podia volver a ser revelada por quien la recibe (except como se indica arriba en el punto 2), y las leyes federales o estatales pueden no seguir protegiendo esta nueva revelación.
6. **ESTA AUTORIZACIÓN NO LE AUTORIZA A USTED PARA HABLAR ACERCA DE MI ATENCIÓN MÉDICA CON NADIE APARTE DEL ABOGADO O DE LA AGENCIA GUBERNAMENTAL ESPECIFICADA EN EL PUNTO 9(b).**

7. Nombre y dirección del proveedor de salud o de la entidad para revelar esta informació:

8. Nombre y dirección de la(s) persona(s) o categoría de la persona a quien se le enviará esta información:

9(a). Especifique la información que se va a revelar:

- □ Expediente medico de (escriba la fecha):_____ a (escriba la fecha): _____
- □ Expediente medico complete, incluyendo historiales del paciente, anotaciones en el consultorio (except la anotaciones de psicoterapia), resultados de análisis, studios radiológicos, películas, Remisiones, consultas, expedients de factures, expedients de seguros y expedients que le enviaron a usted otros proveedores de cuidados de salud.
- □ Otro: _____ Incluya: (*Indique escribiendo sus iniciales)*

_____ **Tratamiento contra el alcoholismo/las drogras**
_____ **Información de Salud Mental**
_____ **Información relacionada con el VIH**
_____ **Prueba de Genetica**

Autorización para hablar sobre la Información de Salud

(b) □ Al escribir las iniciales aquí _____ yo autorizo a _____
Iniciales — Nombre del proveedor de cuidados de salud del individuo

Para hablar acerca de mi información de salud con mi abogado o agencia gubernamental, anotada aquí:

_____
(Nombre y Firma del abogado o Nombre de la Agencia gubernamental)

10. Motivo por el cual se revela la información: □ Solicitado por el individuo □ Otro:	11. Fecha o momento de vencimiento de esta autorización:
12. Si el paciente no firma, escriba el nombre de la persona que firma el formulario:	13. Autoridad legal para firmar en nombre del paciente:

Se han completado todos los puntos de este formulario y se han contestado mis preguntas sobre el mismo. Además, se me ha entregado una copia de este formulario.

_____ Fecha: _____
Firma del paciente o reprensentante autorizado ante la ley.

*** El Virus de Inmunodeficiencia Humana que causa el SIDA. Las Leyes de Salud Pública del Estado de Nueva York (New York State Public Health Law) protegen la información que razonablemente puede identificar a alguien con síntomas o infección por VIH y la información con respect a quienes hayan tenido contacto con esa persona.**

U.S. Department of State
STATEMENT OF CONSENT:
ISSUANCE OF A U.S. PASSPORT TO A MINOR UNDER AGE 16

USE OF THIS FORM

The information collected on this form is used in conjunction with the DS-11, "Application for a U.S. Passport." When a minor under the age of 16 applies for a passport and one of the minor's parents or legal guardians is unavailable at the time the passport is executed, a completed and notarized DS-3053 can be used as the statement of consent. If the required statement is not submitted, the minor may not be eligible to receive a U.S. passport. The required statement may be submitted in other formats provided they meet statutory and regulatory requirements.

FORM INSTRUCTIONS

1. Complete fields 1, 2, and 3. If field 3 is not completed, authorization will be valid for both products.
2. Complete field 4, Statement of Consent, only if you are a non-applying parent or guardian consenting to the issuance of a passport for your minor child. NOTE: Your signature must be witnessed and notarized in field 5.
3. The written consent from the non-applying parent that accompanies an application for a new U.S. passport must not be more than 90 days old. A clear photocopy of the front and back of the non-applying parent's government-issued photo identification presented to the notary is required with the written consent.
4. Please submit this form with your minor child's new DS-11 passport application to any designated acceptance facility, U.S. Passport Agency, U.S. Embassy, or U.S. Consulate abroad.

SPECIAL REQUIREMENTS FOR INSTITUTIONS/ENTITIES GRANTED GUARDIANSHIP

Below is a list of documents **you must** submit with your DS-3053:

1. A **certified** order of a court of competent jurisdiction granting guardianship to the institution/entity. (Photocopies are not acceptable.)
2. A signed statement from the institution/entity **on letterhead** authorizing a specific person to apply for a passport for the child on its behalf. The statement must include the minor's name and the name of the individual(s) authorized to apply for the passport.
3. A photocopy of employee identification documents proving the person applying for the minor's passport works at the institution/entity.

Please ensure that all of the above **do NOT have any conditions** placed on the period of validity of the passport or where the minor may travel. If there are conditions in the statement, a new statement of unequivocal consent is required.

WARNING: False statements made knowingly and willfully on passport applications, including affidavits or other supporting documents submitted therewith, may be punishable by fine and/or imprisonment under U.S. law, including the provisions of 18 U.S.C. 1001, 18 U.S.C. 1542, and/or 18 U.S.C. 1621.

FOR INFORMATION AND QUESTIONS

For passport and travel information, please visit our website at **travel.state.gov**. In addition, contact the National Passport Information Center (NPIC) toll-free at 1-877-487-2778 (TDD 1-888-874-7793) or by e-mail at **NPIC@state.gov**. Customer Service Representatives are available Monday-Friday, 8:00 a.m. - 10:00 p.m. Eastern Standard Time (excluding federal holidays). Automated information is available 24/7.

For information on International Parental Child Abduction, please visit **www.travel.state.gov/childabduction** or contact the Office of Children's Issues by telephone at 1-888-407-4747 or by e-mail at **PreventAbduction1@state.gov**.

PRIVACY ACT STATEMENT

AUTHORITIES: We are authorized to collect this information by 22 U.S.C. 211a et seq.; 8 U.S.C. 1104; 26 U.S.C. 6039E; Executive Order 11295 (August 5, 1966); and 22 C.F.R. parts 50 and 51.

PURPOSE: The primary purpose for soliciting the information is to establish two parent consent for a minor's passport application, as required by Public Law 106-113, Section 236.

ROUTINE USES: This information may be disclosed to another domestic government agency, a private contractor, a foreign government agency, or to a private person or private employer in accordance with certain approved routine uses. These routine uses include, but are not limited to, law enforcement activities, employment verification, fraud prevention, border security, counterterrorism, litigation activities, and activities that meet the Secretary of State's responsibility to protect U.S. citizens and non-citizen nationals abroad. More information on the Routine Uses for the system can be found in System of Records Notices State-05, Overseas Citizen Services Records and State-26, Passport Records.

DISCLOSURE: Failure to provide the information requested on this form may result in the refusal or denial of a U.S. passport application.

PAPERWORK REDUCTION ACT STATEMENT

Public reporting burden for this collection of information is estimated to average 20 minutes per response, including the time required for searching existing data sources, gathering the necessary data, providing the information and/or documents required, and reviewing the final collection. You do not have to supply this information unless this collection displays a currently valid OMB control number. If you have comments on the accuracy of this burden estimate and/or recommendations for reducing it, please send them to: U.S. Department of State, Bureau of Consular Affairs, Passport Services, Office of Legal Affairs and Law Enforcement Liaison, Attn: Forms Officer 44132 Mercure Cir, P.O. Box 1227, Sterling, Virginia 20166-1227.

OMB CONTROL NO. 1405-0129
OMB EXPIRATION DATE: 08-31-2019
ESTIMATED BURDEN: 20 Minutes

U.S. Department of State
STATEMENT OF CONSENT:
ISSUANCE OF A U.S. PASSPORT TO A MINOR UNDER AGE 16

Attention: Read WARNING and FORM INSTRUCTIONS on Page 1

1. MINOR'S NAME

Last	First	Middle

2. MINOR'S DATE OF BIRTH *(mm/dd/yyyy)*

3. THIS AUTHORIZATION IS VALID FOR:

☐ Passport Book and Card ☐ Book Only ☐ Card Only

4. STATEMENT OF CONSENT To be completed by the non-applying parent or guardian using his/her information when not present at the time the applying parent or guardian submits the minor's application. **Statements expire after 90 days.**

I, _____ authorize _____

Print Name (*non-applying parent/guardian*) Print Name (*person applying for minor's passport*)

to apply for a United States passport for my minor child named on this application. My consent is unconditional in regards to passport validity and travel.

_____ _____ _____ _____ _____

Street Address (*non-applying parent*) Apartment City State Zip Code

( ) _____ _____

Area Code Telephone Number E-mail Address

STOP! YOU MUST SIGN THIS FORM IN FRONT OF A NOTARY.

OATH: I declare under penalty of perjury that all statements made in this supporting document are true and correct.

_____ _____

Signature of Non-Applying Parent or Guardian Date *(mm/dd/yyyy)*

NOTE: A clear photocopy of the front and back of the identification you presented to the notary is required with this form.

5. STATEMENT OF CONSENT NOTARIZATION

Name of Notary _____

Print Name (Notary Public)

Location _____

City, State

NOTARY SEAL

Commission Expires _____

Date (*mm/dd/yyyy*)

Identification Presented by Non-Applying Parent or Guardian: ☐ Driver's License ☐ Passport ☐ Military ID ☐ Other *(specify)* _____

ID Number: _____ Place of Issue: _____

Issue Date (*mm/dd/yyyy*): _____ Expiration Date (*mm/dd/yyyy*): _____

OATH: By signing this document, I certify that I am a licensed notary under laws and regulations of the state or country for which I am performing my notarial duties, that I am not related to the above affiant, that I have personally witnessed him/her sign this document, and that I have properly verified the identity of the affiant by personally viewing the above notated identification document and the matching photocopy.

Signature of Notary _____ Date of Notarization _____

Date (*mm/dd/yyyy*)

POWER OF ATTORNEY
NEW YORK STATUTORY SHORT FORM

(a) CAUTION TO THE PRINCIPAL: Your Power of Attorney is an important document. As the "principal," you give the person whom you choose (your "agent") authority to spend your money and sell or dispose of your property during your lifetime without telling you. You do not lose your authority to act even though you have given your agent similar authority.

When your agent exercises this authority, he or she must act according to any instructions you have provided or, where there are no specific instructions, in your best interest. "Important Information for the Agent" at the end of this document describes your agent's responsibilities.

Your agent can act on your behalf only after signing the Power of Attorney before a notary public.

You can request information from your agent at any time. If you are revoking a prior Power of Attorney, you should provide written notice of the revocation to your prior agent(s) and to any third parties who may have acted upon it, including the financial institutions where your accounts are located.

You can revoke or terminate your Power of Attorney at any time for any reason as long as you are of sound mind. If you are no longer of sound mind, a court can remove an agent for acting improperly.

Your agent cannot make health care decisions for you. You may execute a "Health Care Proxy" to do this.

The law governing Powers of Attorney is contained in the New York General Obligations Law, Article 5, Title 15. This law is available at a law library, or online through the New York State Senate or Assembly websites, www.senate.state.ny.us or www.assembly.state.ny.us.

If there is anything about this document that you do not understand, you should ask a lawyer of your own choosing to explain it to you.

(b) DESIGNATION OF AGENT(S):

I, _____ _____

(name of principal) *(address of principal)*

hereby appoint:

_____ _____

(name of agent) *(address of agent)*

_____ _____

(name of second agent) *(address of second agent)*

as my agent(s).

If you designate more than one agent above, they must act together unless you initial the statement below.

(____) My agents may act SEPARATELY.

(c) DESIGNATION OF SUCCESSOR AGENT(S): (OPTIONAL)
If any agent designated above is unable or unwilling to serve, I appoint as my successor agent(s):

_____ _____
(*name of successor agent*) (*address of successor agent*)

_____ _____
(*name of second successor agent*), (*address of second successor agent*)

Successor agents designated above must act together unless you initial the statement below.

(____) My successor agents may act SEPARATELY.

You may provide for specific succession rules in this section. Insert specific succession provisions here:

(d) This POWER OF ATTORNEY shall not be affected by my subsequent incapacity unless I have stated otherwise below, under "Modifications".

(e) This POWER OF ATTORNEY DOES NOT REVOKE any Powers of Attorney previously executed by me unless I have stated otherwise below, under "Modifications".

If you do NOT intend to revoke your prior Powers of Attorney, and if you have granted the same authority in this Power of Attorney as you granted to another agent in a prior Power of Attorney, each agent can act separately unless you indicate under "Modifications" that the agents with the same authority are to act together.

(f) GRANT OF AUTHORITY:
To grant your agent some or all of the authority below, either
(1) Initial the bracket at each authority you grant, or
(2) Write or type the letters for each authority you grant on the blank line at (P), and initial the bracket at (P). If you initial (P), you do not need to initial the other lines.

I grant authority to my agent(s) with respect to the following subjects as defined in sections 5-1502A through 5-1502N of the New York General Obligations Law:

(____) (A) real estate transactions;

(____) (B) chattel and goods transactions;

(____) (C) bond, share, and commodity transactions;

(____) (D) banking transactions;

(____) (E) business operating transactions;

(____) (F) insurance transactions;

(____) (G) estate transactions;

(____) (H) claims and litigation;

(____) (I) personal and family maintenance: If you grant your agent this authority, it will allow the agent to make gifts that you customarily have made to individuals, including the agent, and charitable organizations. The total amount of all such gifts in any one calendar year cannot exceed five hundred dollars;

(____) (J) benefits from governmental programs or civil or military service;

(____) (K) health care billing and payment matters; records, reports, and statements;

(____) (L) retirement benefit transactions;

(____) (M) tax matters;

(____) (N) all other matters;

(____) (O) full and unqualified authority to my agent(s) to delegate any or all of the foregoing powers to any person or persons whom my agent(s) select;

(____) (P) EACH of the matters identified by the following letters: A-H and J-O

You need not initial the other lines if you initial line (P).

(g) MODIFICATIONS: (OPTIONAL)

In this section, you may make additional provisions, including language to limit or supplement authority granted to your agent. However, you cannot use this Modifications section to grant your agent authority to make gifts or changes to interests in your property. If you wish to grant your agent such authority, you MUST complete the Statutory Gifts Rider.

(_____) (Q) Accept transfers or distributions from any trustee of any trust;

(_____) (R) Enter any safe deposit box or other place of safekeeping standing in my name alone or jointly with another and to remove the contents;

(_____) (S) Retain, discharge and pay for the services of attorneys, accountants, financial planners, home care providers, social workers and other health care professionals;

(_____) (T) Make statutory elections by testate or intestate succession or by inter vivos transfer consistent with Paragraph (c) of Section 2-1.11 of the New York Estates, Powers and Trusts Law and/or Section 2518 of the Internal Revenue Code;

(_____) (U) To enroll me in a pooled income trust (in the event of a disabled child);

(_____) (V) Disclose medical records and other personal information. Act as or appoint a third party to act as my personal representative for all purposes of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Confidentiality of Alcohol and Drug Abuse Patient Records Confidentiality of Mental Health Records, New York Public Health Law §2782 (Confidentiality of HIV-related information), or any amendments or similar legislation hereafter enacted. Any such

personal representative is authorized to obtain, review, photocopy and release to any individual any or all my individually identifiable health insurance and medical records regarding any past, present or future medical or mental health care condition. The authority given my agent or appointed personal representative shall supersede any prior agreement that I may have made with my health care providers to restrict access to or disclosure my individually identifiable health information; and

(_____) (W) Reimburse my agent under a health care proxy for any costs (including legal fees) reasonably incurred in or as a result of acting pursuant to such proxy;

(_____) (X) Borrow or lend money on such terms and with such security, if any, as my agent may decide in his/her sole discretion;

(_____) (Y) Waive attorney-client and other similar privileges to facilitate consultations between my agent herein appointed and my attorney and other advisors;

(_____) (Z) Unless reasonable cause exists to require otherwise, the agent shall not be obligated by the Monitor, if I have so appointed one, to provide financial documents, information or accountings more frequently than annually;

(_____) (AA) This power of attorney shall not be revoked by any specific, limited, financial or banking power of attorney subsequently executed by me unless such subsequent power of attorney specifically provides that it revokes this power of attorney by referring to the date of my execution of this document;

(_____) (BB) Without in any way limiting any other rights or remedies with may exist, to also bring such action as is authorized pursuant to GOL §5-1504(2) against any financial institution or third party who refuses to honor this statutory short form power of attorney because:

(1) it is not on a form prescribed by the financial institution or third part to whom the power of attorney is presented,
(2) there has been a lapse of time since the execution of the power of attorney, or
(3) there has been a lapse of time between the date acknowledgment of the signature of the principal and the date of the acknowledgment of the signature of any agent.

Such authority shall specifically include, without limitation, the authority to seek actual, punitive, and any other appropriate damages, and to seek such court costs, disbursements, legal fees and monetary sanctions as may be allowable at law or in equity against any such party who refuses to honor this instrument.

(_____) (II) EACH of the matters identified by the following letters: Q, R, S, T, U, V, W, X, Y, Z, AA, and BB.

You need not individually initial items Q through BB if you initial line ("II")

If any one or more of the provisions contained in this Modifications sections shall for any reason be held invalid, illegal or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect

any other provision hereof and this Power of Attorney shall be construed as if such invalid, illegal or unenforceable provision had never been contained herein.

(h) CERTAIN GIFT TRANSACTIONS: STATUTORY GIFTS RIDER (OPTIONAL)

In order to authorize your agent to make gifts in excess of an annual total of $500 for all gifts described in (I) of the grant of authority section of this document (under personal and family maintenance), you must initial the statement below and execute a Statutory Gifts Rider at the same time as this instrument. Initialing the statement below by itself does not authorize your agent to make gifts. The preparation of the Statutory Gifts Rider should be supervised by a lawyer.

(____) (SGR) I grant my agent authority to make gifts in accordance with the terms and conditions of the Statutory Gifts Rider that supplements this Statutory Power of Attorney.

(i) DESIGNATION OF MONITOR(S): (OPTIONAL)

If you wish to appoint monitor(s), initial and fill in the section below:

(____) I wish to designate _____, whose address(es) is (are) _____, as monitor(s). Upon the request of the monitor(s), my agent(s) must provide the monitor(s) with a copy of the power of attorney and a record of all transactions done or made on my behalf. Third parties holding records of such transactions shall provide the records to the monitor(s) upon request.

(j) COMPENSATION OF AGENT(S): (OPTIONAL)

Your agent is entitled to be reimbursed from your assets for reasonable expenses incurred on your behalf. If you ALSO wish your agent(s) to be compensated from your assets for services rendered on your behalf, initial the statement below. If you wish to define "reasonable compensation", you may do so above, under "Modifications".

(____) My agent(s) shall be entitled to reasonable compensation for services rendered.

(k) ACCEPTANCE BY THIRD PARTIES:

I agree to indemnify the third party for any claims that may arise against the third party because of reliance on this Power of Attorney. I understand that any termination of this Power of Attorney, whether the result of my revocation of the Power of Attorney or otherwise, is not effective as to a third party until the third party has actual notice or knowledge of the termination.

(l) TERMINATION:

This Power of Attorney continues until I revoke it or it is terminated by my death or other event described in section 5-1511 of the General Obligations Law.

Section 5-1511 of the General Obligations Law describes the manner in which you may revoke your Power of Attorney, and the events which terminate the Power of Attorney.

(m) SIGNATURE AND ACKNOWLEDGMENT:

In Witness Whereof I have hereunto signed my name on the ____ day of _____, 20__

PRINCIPAL signs here: ====> _____

STATE OF NEW YORK)
ss:
COUNTY OF WESTCHESTER)

On the ____ day of _____, _____, before me, the undersigned, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity, and that by his/her signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

_____
Notary Public

(n) IMPORTANT INFORMATION FOR THE AGENT:

When you accept the authority granted under this Power of Attorney, a special legal relationship is created between you and the principal. This relationship imposes on you legal responsibilities that continue until you resign or the Power of Attorney is terminated or revoked. You must:

(1) act according to any instructions from the principal, or, where there are no instructions, in the principal's best interest;

(2) avoid conflicts that would impair your ability to act in the principal's best interest;

(3) keep the principal's property separate and distinct from any assets you own or control, unless otherwise permitted by law;

(4) keep a record or all receipts, payments, and transactions conducted for the principal; and

(5) disclose your identity as an agent whenever you act for the principal by writing or printing the principal's name and signing your own name as "agent" in either of the following manners: (Principal's Name) by (Your Signature) as Agent, or (your signature) as Agent for (Principal's Name).

You may not use the principal's assets to benefit yourself or anyone else or make gifts to yourself or anyone else unless the principal has specifically granted you that authority in this document, which is either a Statutory Gifts Rider attached to a Statutory Short Form Power of Attorney or a Non-Statutory Power of Attorney. If you have that authority, you must act according to any instructions of the principal or, where there are no such instructions, in the principal's best interest.

You may resign by giving written notice to the principal and to any co-agent, successor agent, monitor if one has been named in this document, or the principal's guardian if one has been appointed. If there is anything about this document or your responsibilities that you do not understand, you should seek legal advice.

Liability of agent: The meaning of the authority given to you is defined in New York's General Obligations Law, Article 5, Title 15. If it is found that you have violated the law or acted outside the authority granted to you in the Power of Attorney, you may be liable under the law for your violation.

(o) AGENT'S SIGNATURE AND ACKNOWLEDGMENT OF APPOINTMENT:

It is not required that the principal and the agent(s) sign at the same time, nor that multiple agents sign at the same time.

I/we, , have read the foregoing Power of Attorney. I am/we are the person(s) identified therein as agent(s) for the principal named therein.

I/we acknowledge my/our legal responsibilities.

Agent(s) sign(s) here: ==> _____

_____

STATE OF NEW YORK)
COUNTY OF)ss:

On the day of , 201 , before me, the undersigned, personally appeared, , personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity, and that by his/her signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

_____
Notary Public

STATE OF NEW YORK)
COUNTY OF)ss:

On the day of , 201, before me, the undersigned, personally appeared, , personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity, and that by his/her signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

_____
Notary Public

(p) SUCCESSOR AGENT'S SIGNATURE AND ACKNOWLEDGMENT OF APPOINTMENT:

It is not required that the principal and the SUCCESSOR agent(s), if any, sign at the same time, nor that multiple SUCCESSOR agents sign at the same time. Furthermore, successor agents can not use this power of attorney unless the agent(s) designated above is/are unable or unwilling to serve.

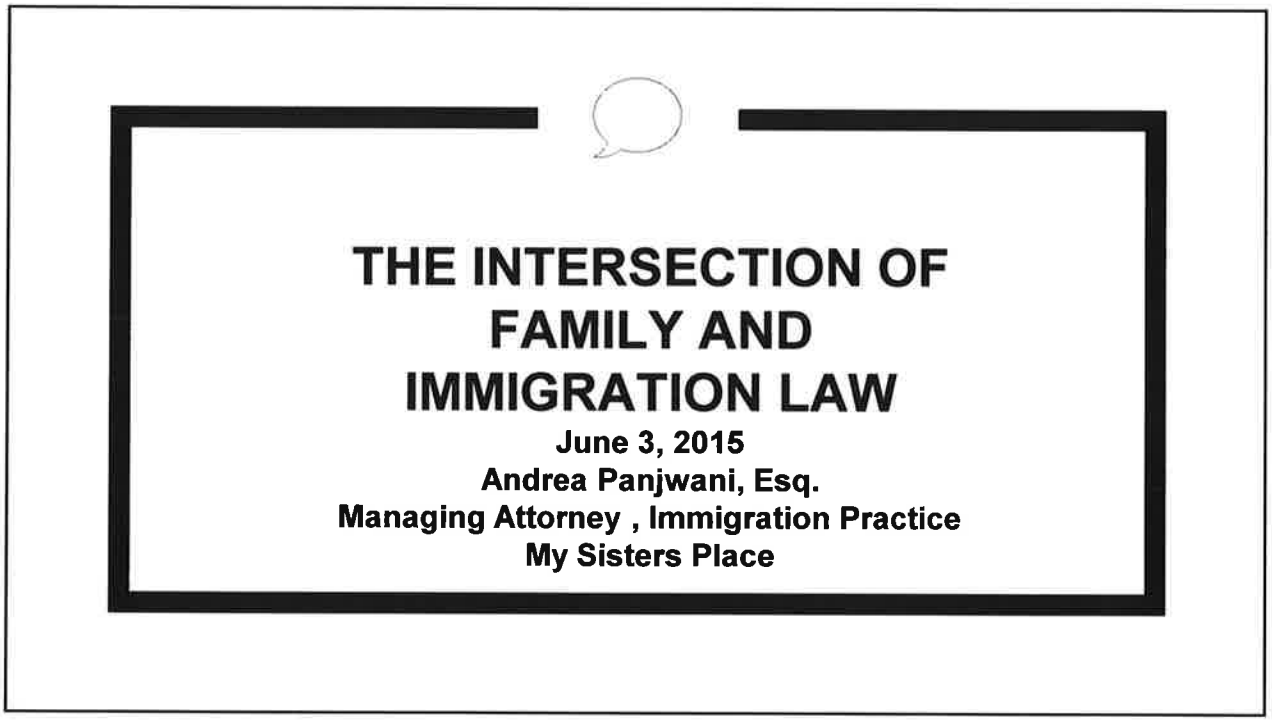
I/we, , have read the foregoing Power of Attorney. I am/we are the person(s) identified therein as SUCCESSOR agent(s) for the principal named therein and acknowledge my legal responsibilities.

Successor Agent(s) sign(s) here: ==> _____

STATE OF)
COUNTY OF)ss:

On the _____ day of _____, 20, before me, the undersigned, personally appeared , personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity, and that by his/her signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

_____
Notary Public



THE INTERSECTION OF FAMILY AND IMMIGRATION LAW

June 3, 2015

Andrea Panjwani, Esq.
Managing Attorney , Immigration Practice
My Sisters Place

IMMIGRANT DEFENSE PROJECT

The Immigrant Defense Project promotes fundamental fairness for immigrants accused or convicted of crimes. We seek to minimize the harsh and disproportionate immigration consequences of contact with the criminal justice and family court systems by:
1) working to transform unjust deportation laws and policies and
2) educating and advising immigrants, their defenders, and other advocates.

7

DETAINED & DEPORTED PARENTS

ICE PARENTAL INTERESTS DIRECTIVE

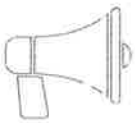
ICE issued this non-binding policy memorandum in 2013. The directive was issued to protect the parental rights of immigrants in removal proceedings, with a focus on parents who are detained and/or deported.
https://www.ice.gov/doclib/detention-reform/pdf/parental_interest_directive_signed.pdf

ICE PARENTAL INTERESTS DIRECTIVE

- Reiterates prosecutorial discretion for primary caretakers of children/dependent adult.
- Detention in facility close to family.
- Participation in family court hearings.
  - Transportation or video/tele conferencing.
  - Transfer to nearby detention facility.

ICE PARENTAL INTERESTS DIRECTIVE

- Facilitate court-ordered visitation with children.
  This could apply to all court-ordered services.
- Facilitate document collection (e.g. passport application) and share travel itinerary if children are repatriating with parent.
- Post-deportation, if parents face TPR, they can seek humanitarian parole for the sole purpose of participating in TPR proceeding.



WHO TO CALL

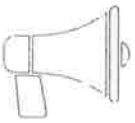
Parental Interests Directive Coordinators

- Andrew Lorenzen Strait (DC), Andrew.R. Lorenzen.Strait@ice.dhs.gov
- Diane McConnell (NY), Diane.McConnell@ice.dhs.gov
- Jacob Antoninis (NY), jacob.a.antoninis@ice.dhs.gov

Deportation Officer

ACS Immigrant Services Coordinator

- Colleen Duffy, colleen.duffy@acs.nyc.gov



RESOURCES

Women's Refugee Commission
https://womensrefugeecommission.org/programs/migrant-rights

Toolkit for Detained and Deported Parents
*Appendix G: Child Welfare Agencies in Mexico and Central America
https://womensrefugeecommission.org/programs/migrant-rights/parental-rights/toolkit-and-educational-resources

IMUMI: Institute for Women and Migration (Mexico)
http://www.imumi.org/

Toolkit for Families Repatriating to Mexico (Spanish)
http://imumi.org/attachments/2014/guia-familias-trasnacionales.pdf

Educational Barriers for US Citizen Children Repatriating
https://ia600308.us.archive.org/24/items/DerechoALaEducacionDeNinezEnContextosMigratoriosInglesBINATIONAL/Derecho%20a%20la%20educaci%C3%B3n%20de%20ni%C3%B1ez%20en%20contextos%20migratorios,%20ingl%C3%A9s_BINATIONAL.pdf

HELPFUL RESOURCES

- IDP HOTLINE: (212) 725-6422
- Immigration Benchbook for Family and Juvenile Judges available through Immigration Legal Resource Center, www.ilrc.org
- Introductory Guide to New York City Family Court available through New York City Bar Association, www.nycba.org
- Immigration Law and the Family, West Group
- Immigration Advocates Network, www.immigrationadvocates.org

THANKS!

Any questions?

You can find us at

apanjwani@immigrantdefenseproject.org
svendzules@bds.org