COHESIVE HEALTHCARE MANAGEMENT & CONSULTING
Mangum Regional Medical Center

Statement of Voluntary Relinquishment of Infant

- ***The hospital may request, but not demand, any information about the child that the parent is willing to share. The hospital staff is encouraged to ask about, but not demand, the details of any relevant medical history relating to the child or the parents of the child. The entity shall respect the wish of the parent if the parent desires to remain anonymous.***
- ***The information contained in this document is strictly confidential and will be shared with only those individuals with a need to know (i.e. Quality Manager, Hospital Administrator)***

Instructions

(The hospital may request information, but not demand information)

1. Ask the individual if they are willing to share any or all of the information as outlined below.

2. Explain to the individual the purpose of this document is only to provide relevant information they would like to ***voluntarily share with the hospital and will not be used in a punitive manner or they have the right to refuse to give information to the hospital.***

2. The Hospital personnel will check each box or fill-in information the parent is willing to share. The individual providing the information must have the freedom to share information without prodding or coercion by the hospital staff.

3. Contact the Department of Human Services listed below:

Statewide 24-hour Child Abuse and Neglect Hotline
1-800-522-3511

4. Forward this document to the Quality Manager upon completion.

Infant/Parent Information

(Hospital staff to complete this section based upon the information received from the parent)

☐ I hereby express my will as the parent of this infant to voluntarily relinquish my infant to the hospital and have no intent to return for the child.

Witnessed by:

1. Name & Title: _____ Date: _____/_____/_____

2. Name & Title: _____ Date: _____/_____/_____

□ I wish to remain anonymous and do not want to share any information with the hospital personnel.

□ I agree to share any or all information as requested by the hospital. I understand I may choose what if any information I would like to share. This decision has been made by my own free will without demand or coercion by the hospital staff.

□ I hereby state the infant is _____ days old and was born on _____/_____/_____.

☐ Place of Birth: _____.

☐ I hereby state the infant is a ☐ male ***or*** I hereby state the infant is a ☐ female.

☐ I am willing to share any or all of the details of any relevant medical history relating to the infant or parentage.

□ I am ***NOT*** willing to share any or all of the details of any relevant medical history relating to the child or parentage.

□ I wish to leave my name and contact information with the hospital.

Name: _____ Phone: (____) _____-_____

To Be Completed By Hospital Staff

☐ I hereby state the hospital has made no demands of the person relinquishing the infant for any or all of the information contained in this document, but only as voluntarily expressed by the person.

Name & Title: _____ Date: _____/_____/_____

Date of Event: _____/_____/_____ Time of Event: _____/_____/_____

☐ MSE Completed by: _____ Date: _____/_____/_____

☐ I confirm during the transfer of the infant from the hospital to DHS custody that no material deterioration of the infant is likely, to result from or occur within reasonable medical probability.

Medical Provider: _____ Date: _____/_____/_____

Release of Infant

Department of Human Services (DHS) Notified: Date: ____/____/____ Time: _____:_____

Name of Department of Human Services Representative: _____

Contact Number of DHS Representative: (_____) _____-_____

Infant released to:

Name & Title of DHS Representative: _____

Date: ____/____/____ Time: ____:____

Infant Condition Upon Release: Vital Signs: Temp:_____ Pulse: _____ Resp: _____ BP:____/_____

_____

_____

_____

_____ _____/_____/_____

Name of Person Completing Report *Date*