AUTHORIZATION FOR THIRD PARTY TO CONSENT

TO TREATMENT OF MINOR

I am the:

_____ Parent

_____ Guardian

_____ Other Person having legal custody _____

(Describe legal relationship)

of _____, a minor.

(Name of minor)

I hereby authorize_____, to act as my agent to consent to any X-ray examination, anesthetic, medical, or surgical diagnosis or treatment, and hospital care which is recommended by, and to be rendered under the general or special supervision of, any licensed doctor, whether such diagnosis or treatment is rendered at the doctor's office or at a hospital.

I understand that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being requited, but is given to provide authority to the above-named agent to give consent to any and all such diagnosis, treatment, or hospital care which a licensed doctor recommends.

These authorizations shall remain effective until _____, unless sooner revoked in writing.

(month, day, and year)

Signature: _____

(Parent, guardian, other person above having legal custody)

Date/Time: _____

Print Name: _____

(Parent, guardian, other person above having legal custody)

Witness to Signature: _____

Date/Time: _____

_____ Copy given to Agent *(Initials)*

_____ Original placed in chart *(Initials)*

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