Authorization for Third Party to Consent to Treatment of a Minor

Patient Name: _____

Patient DOB: _____

I/We _____, the parents/guardians of said minor listed above , hereby authorize designated agent(s) to act as our agents to consent to any x-ray examination, medical, or surgical treatment, and hospital care which is recommended by, and to be rendered under the general or special supervision of, any licensed doctor or physician assistant, whether such diagnosis or treatment is rendered at the doctor's office or at a hospital.

We understand that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority to these agents to give consent to any and all such diagnosis, treatment, or hospital care which a licensed doctor or physician assistant recommends.

_____

Designated Agent(s):

_____

Parent(s) Signature:

_____

Parent(s) Name – in print:

_____

Date: