Children's Primary Care Medical Group

AUTHORIZATION FOR THIRD PARTY TO CONSENT TO TREATMENT OF MINOR LACKING LEGAL CAPACITY TO CONSENT

I am the **___ Parent**

___ Guardian

___ Other person having legal custody _____
(describe legal relationship)

of ***(name of minor)*** _____**, a minor.**

I hereby authorize the following individuals to act as my agent to consent to any x-ray examination, anesthetic, medical, surgical or dental diagnosis, immunization 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.

Name:_____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I 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 the above-named agent to give consent to any and all such diagnosis, treatment or hospital care, which a licensed doctor or dentist recommends.

Date: _____ Signature: _____