AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR

Please print or type:

I, _____ , parent or guardian

of _____ , a minor, do hereby

authorize name(s): _____

Phone numbers: Home: _____ Work: _____ Cell: _____

as my agent(s) to consent to any x-ray examination, anesthetic, medical or surgical evaluation, diagnosis or treatment and care which is deemed advisable by, and is to be rendered under, the general or special supervision of, a licensed physician. This authorization specifically includes hospital admission if such is deemed necessary by the physician. It is understood that this authorization is given in advance of any specific evaluation, diagnosis, treatment and care required, but is given to provide authority and power on the part of my aforesaid agent(s) to give specific consent to any and all such evaluation, diagnosis, treatment or care which a physician, in the exercise of his / her best judgment, may deem advisable.

This authorization also grants to my agent(s) the power to sign for release of information to any third party payors who may be responsible for part or all of the cost of the services provided. This authorization shall remain effective from _____ to _____ unless sooner revoked in writing delivered to said agent(s).

_____ _____

Date Signature of parent, guardian or other legal representative

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Patient Information For Minor Listed Above

Date of Birth: _____ Mailing Address: _____

Patient's Personal Physician: _____

Physician's Address: _____

_____

Physician's Phone Number: _____

Patient Medications: _____

Patient Allergies: _____

Significant Medical History: _____

Guarantor: _____

Guarantor's Employer: _____

Responsible Insurance Company: _____

Group Number: _____

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