AUTHORIZATION FOR THIRD PARTY CONSENT FOR TREATMENT OF A MINOR

I am the

___________(Initial) PARENT

___________(Initial) GUARDIAN

___________(Initial) 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

(Name of Agent)

any examination, anesthetic, medical, surgical, or laboratory diagnosis or treatment, and hospital care which is recommended by, and to be rendered under 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.

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 physician assistant recommends.

The authorization shall remain effective until ________________________, unless sooner

(Month, Day, and Year)

revoked in writing.

Signature:____ Date:___________________

Printed Name:_____________________________________

Witness to Signature:________________________________ Date:___________________

Minor's Name:____________________________________ DOB:___________________