ADRIATICA
Women's Health
OB/GYN

AUTHORIAZATION 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**

(Name of Agent)

agent to consent to any X-ray examination, anesthetic, medical, surgical, dental diagnosis or treatment, and hospital care which is recommended by, and to be rendered under the general or special supervision of, any licensed physician, 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 physician recommends.

These authorizations shall remain effective until _____**, unless sooner revoked**

(month, day, and year)

in writing.

Signature: _____ **Date/Time:** _____/_____

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

Print Name: _____

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

Witness to Signature: _____ **Date/Time:** _____/_____

MINOR'S NAME: _____ **DOB:** _____