



**AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR WHEN LEGAL GUARDIAN and/or PARENT(S) IS UNABLE TO BRING PATIENT**

I, \_\_\_\_\_, parent or guardian of \_\_\_\_\_,

do hereby authorize \_\_\_\_\_ as my agent(s) to consent to any x-ray examination, anesthesia, medical evaluation and/or treatment, surgery evaluation, and/or treatment, diagnosis of care which is deemed advisable by and is to be rendered under, the general or special supervision of a licensed physician. This authorization includes hospital admission if such is deemed necessary by the physician. It is understood that this authorization 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, office treatment, anesthetic administration or surgical treatment(s) 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 payers 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

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

.....  
**PATIENT INFORMATION FOR MINOR LISTED ABOVE**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Home Address: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

Primary Care Physician or Pediatrician: \_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_

Person Who Carries This Insurance: \_\_\_\_\_

Address of the Insured (If different from above): \_\_\_\_\_

Insurance ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_