Patterson & Tedford Pediatrics
with you every step of the way

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AUTHORIZATION FOR AGENT TO CONSENT TO MEDICAL TREATMENT OF A MINOR (2018)

I hereby authorize _____

(an adult into whose care the minor(s) has/have been entrusted) to consent to any examination, treatment, medical or surgical diagnosis, x-ray, anesthetic or hospital care of the below-named minor(s) deemed advisable by a licensed physician and surgeon and provided by that physician or under that physician's supervision, regardless of where that treatment is provided.

_____
Name and address of minor

_____
Name and address of minor

_____
Name and address of minor

Signature:_____ Date:_____

Printed Name of Parent or Guardian:_____

Please specify your relationship to minor(s) listed:

[ ] I am a parent with legal custody
[ ] I am a guardian with legal custody

This authorization must be filled out <u>each</u> time the minor(s) parent/guardian is NOT in attendance with the minor(s).

This authorization is made under Family Code 6910.

Updated 1.1.18

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