Hoag Medical Group Pediatrics

AUTHORIZATION FOR THIRD PARTY TO CONSENT TO THE TREATMENT OF A MINOR

PATIENT LAST NAME (PLEASE PRINT) ______________________ PATIENT FIRST NAME (PLEASE PRINT) ______________________

DATE OF BIRTH ______________________ MRN ______________________

I, the undersigned, parent/legal guardian/person having legal custody of______________________ do hereby authorize ______________________ as agent(s) to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment which is deemed advisable by, and is to be rendered under the general or special supervision of licensed provider employed by Hoag Medical Group, when such diagnosis or treatment is rendered at the office of said provider.

It is understood that this authorization is given in advance of any specific diagnosis or treatment being required, but is given to provide authority to the above-named agent(s) to give specific consent to any and all such diagnosis or treatment which the provider, in the exercise of his/her best judgement may deem advisable.

This authorization is given pursuant to the provisions of California Family Code 6910.

This authorization shall remain effective until ______________ (DATE), unless sooner revoked in writing.

PRINT NAME ______________ SIGNATURE ______________ DATE ______________

Relationship to minor:

- Parent
- Legal Guardian
- Person having legal custody

WITNESS (PRINT NAME) ______________ SIGNATURE ______________ DATE ______________