☐ Hoag Medical Group ☐ Hoag Urgent Care ☐ Hoag Physician Partners ☐ Hoag Concierge Medicine ☐ Hoag Specialty Clinic

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

On certain occasions families may wish their child to be brought to our office by someone other than the parent/legal guardian. In these circumstances, written consent is required. If you think that there's a possibility another adult (18 years or older) may bring your child to our office, then please complete and sign this form.

PATIENT LAST NAME (PLEASE PRINT) ______________________

PATIENT FIRST NAME (PLEASE PRINT) ______________________

DATE OF BIRTH ______________________

I, the undersigned, parent/legal guardian/person having legal custody of **patient named above** do hereby authorize:

Grandparent (Name): ______________________ Phone: ______________

Care Giver (Name): ______________________ Phone: ______________

Stepparent (Name): ______________________ Phone: ______________

Other (Name): ____________ Relationship: ____________ Phone: ______________

Other (Name): ____________ Relationship: ____________ Phone: ______________

Other (Name): ____________ Relationship: ____________ Phone: ______________

☐ I decline to add any third parties to consent to any treatment of the minor named above.

The individuals listed above may act 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 the Hoag entity selected above and affiliates, 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 judgment may deem advisable.

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

The most current Authorization for Third Party to Consent to the Treatment of a Minor is the active authorization and remains in effect until a new Authorization for Third Party to Consent to the Treatment of a Minor is completed.

Print Name: ______________________ Signature: ______________________ Date/Time: ____________

Relationship to minor:

☐ Parent

☐ Legal Guardian

☐ Other person having legal custody. Describe legal relationship to minor: ____________

PATIENT LABEL