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 _____, a minor, do hereby authorize the following

1._____ 2. _____ as my agent(s) to consent to any, medical evaluation and/or treatment, diagnosis or care which is deemed advisable by and is to be rendered under, the general or special supervision of a licensed 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 and office treatment, which a physician, in the exercise of his/her best judgment, may deem advisable. This authorization shall remain effective from _____/_____/_____ to _____/_____/_____, unless sooner revoked in writing delivered to said agent(s).

Print Name: _____
Signature: _____
Date: _____ **Acct #:** _____