Authorization For Third Party

(To consent to treatment of minor lacking capacity to consent)

Date _____

I/we, the undersigned, parent(s)/person having legal custody/legal guardian of _____ _____, do hereby authorize _____ as agent(s) for the undersigned, to consent to any X-ray examination, anesthetic/medical/surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician/surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of the said physician or at said hospital.

It is understood that this authorization may be given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority to power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which a physician, meeting the requirements of this authorization, may, in the exercise of their best judgment, deem advisable.

I/we hereby authorize any hospital which has provided treatment to the above named minor(s) to surrender physical custody of such minor(s) to the above named agent(s) upon the completion of treatment.

These authorizations shall remain effective until _____ unless sooner revoked in writing delivered to said agent(s).

Signature of parent/legal guardian/person having legal custody (indicate relationship next to signature):

Signature_____ Relationship _____

_____ _____

_____ _____