larchmont pediatrics
pediatric and adolescent medicine

AUTHORIZATION FOR AGENT TO CONSENT TO MEDICAL TREATMENT OF A MINOR

I am the parent, guardian, or person having legal custody of (*name, date of birth, and address of minor)*

_____

_____, a minor. I hereby authorize (*name of adult 21 years or older into whose care the minor has been entrusted*) _____ to act as my agent to consent to any x-ray, examination, anesthetic, medical,or surgical diagnosis or treatment and hospitaldeemed advisable by a licensed physician and provided by that physician or under that physician's supervision, regardless of where the treatment is provided.I understand that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority to the above named agent to give consent to any and all such diagnosis, treatment, or hospital care which a licensed physician recommends.

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

Signed:_____ Dated:_____

Print Name: _____

Please specify relationship to minor:

( ) parent with legal custody

( ) guardian with legal custody

This authorization will remain in effect until _____
(expiration date of this authorization)

Relationship of authorized adult to minor _____

Address and phone number of authorized adult _____

_____

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