

Medical Authorization for Minors

I, _____, the parent of or legal guardian of _____, a minor, do hereby authorize any one or more of _____,

_____ or _____,

as agents for myself in my absence or incapacitation to consent to any x-ray examination and anesthetic, medical or surgical diagnosis or treatment and medical care which is deemed advisable by and is to be rendered under the general or special supervision of any physician or surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any hospital whether or not such diagnosis or treatment is rendered at the office of said physician or at said hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of the aforesaid agents to give specific consent to any and all such diagnosis, treatment or hospital care which aforementioned physician in the exercise of his or her best judgement may deem advisable. I hereby authorize any hospital which has provided treatment to the above-named minor to surrender physical custody of such minor to the above-named agents upon the completion of treatment.

These authorizations shall remain effective until _____, _____.

Signature of Parent or Legal Guardian: _____

Date: _____

STATE OF _____

COUNTY OF _____

SUBSCRIBED AND SWORN TO before me this _____ day of _____, 20____

(notary seal)

Notary Public

My Commission Expires: _____