PLACE STICKER HERE

NAME _____

DOB _____ DATE _____

# AUTHORIZATION FOR THIRD PARTY TO CONSENT TO TREATMENT OF MINOR LACKING CAPACITY TO CONSENT

(I)(We), the undersigned, parent(s)/person having legal custody/legal guardianship of (*Name of minor*) _____, a minor, do hereby authorize

*(Name of agent)* _____

_____ as agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical or 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 and surgeon licensed under the provisions of the Medical Practice Act, whether such diagnosis or treatment is rendered at the office of the physician or at the 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 to the above described 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 his/her best judgment, deem advisable.

This authorization is given pursuant to the provisions of Family code Section 6910.

(I)(We) hereby authorize any provider that has provided treatment to the above-named minor pursuant to the provisions of Family Code Section 6910 to surrender physical custody of such minor to (my) (our) above named agent(s) upon the completion of treatment. This authorization is given pursuant to Health and Safety Code Section 1283.

These authorizations shall remain effective until *(month and day)* _____, 20_____, unless sooner revoked in writing delivered to the agent(s) noted above.

Date: _____

Signature: _____
*(Circle relationship: parent / legal guardian / person having legal custody)*

Signature: _____
*(Parent)*