Mathiesen Memorial Health Clinic

Authorization for Consent for Medical Treatment of Minor Child

I hereby give authorization for my child_______________________________, to receive treatment by the medical staff as well as any other ancillary service, such as, 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 on the medical staff of any hospital.

I also give my permission for _______________________________to request any
Name
Medical Treatment to be given to my child, and to act on my behalf to consent to said treatment for my child in my absence.

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 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 his/her best judgment, deem advisable.

This authorization is effective immediately and is subject to revocation at any time, except to the extent that action has already been taken. Otherwise, this authorization expires one (1) year from the date of signing.

_______________________________ Witness Signature

_______________________________ Parent or Legal Guardian Signature

____________________ Date

____________________ Date

Patient Name____________________DOB____________MR#_______________