Forest Pediatrics

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AUTHORIZATION FOR AGENT TO CONSENT TO MEDICAL TREATMENT OF A MINOR

I hereby authorize _____(an adult into whose care the minor(s) has been entrusted) to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care of _____(name(s) of minor(s)) deemed advisable by a licensed physician and surgeon and provided by that physician or under that physician's supervision, regardless of where that treatment is provided.

This authorization is made under Family Code §6910.

Signed: _____ Dated: _____

Print Name: _____

Please specify relationship to minor: [ ] parent with legal custody
[ ] guardian with legal custody

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