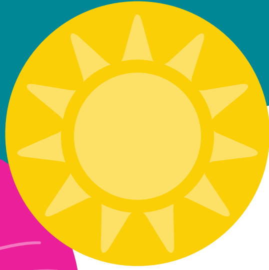

Temporary Authorization and Consent for Treatment of a Minor

I, the parent or legal guardian of ______________________________ _____/_____/_____

(Patient's Name) (Patient's DOB)

Authorize the following individuals to accompany my child, make decisions for treatment necessary by a medical provider and sign any necessary waivers at Providence Scholls Pediatrics in my absence: p

____

(Name) (Relationship to Patient) (Phone #)

____

(Name) (Relationship to Patient) (Phone #)

____

(Name) (Relationship to Patient) (Phone #)

I understand that this consent authorization is given in advance of any specific diagnosis, treatment or hospital care being required in order to provide authority for a licensed physician to render any and all diagnosis, treatment or hospital care deemed advisable by the attending provider. I understand that I am responsible for settling any costs arising from this care provided in my absence.

This consent will remain in effect until the end of the calendar year.

____

Parent or Legal Guardian Signature Date Print Name