Chino Hills Family Medical Group

Authorization for Minor Patient to Consent to Treatment of Self

Patient Name: _____ Patient DOB: _____

I authorize, CHINO HILLS FAMILY MEDICAL GROUP to treat, _____ (name of patient) for medical treatment with my consent as their parent or legal guardian.

Medical treatment, for the purpose of this Authorization, is defined as any necessary medical and/or surgical diagnosis or treatment, laboratory testing, anesthesia or diagnostic imaging as deemed advisable and provided by a licensed physician or healthcare provider under that physician's supervision.

I understand and agree that the signature and date on this form will not expire without written notice or in the case that a minor becomes an adult. A copy of this form is considered as valid as the original.

This authorization is made under Family Code §6910.

Signed: _____ **Date**: _____

Print Name: _____

Relationship to Patient: □ Parent □ Legal Guardian

□Other Person with Legal Custody _____