

**Authorization for Third Party to Consent to Treatment of a Minor**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of authorized adult) to consent to medical treatment of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a minor.

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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_