AUTHORIZATION FOR THIRD PARTY TO CONSENT
TO TREATMENT OF MINOR

I am the
___Parent
___Guardian
___Other person having legal custody ________________________________(Describe legal relationship)

of ____________________________________________________________, a minor.

(Name of Minor)

I hereby authorize ____________________________________________________________, to act as my

(Name of Agent)

agent to consent to any x-ray examination, anesthetic, medical, surgical, dental diagnosis or
treatment, or hospital care that is recommended by and rendered under the general or special
supervision of any licensed doctor or dentist, whether such diagnosis or treatment is rendered at
the doctor’s office or at a hospital.

I understand that this authorization is provided in advance of any specific diagnosis, treatment, or
hospital care being required and grants authority to the above-named agent to give consent to any
and all such diagnosis, treatment, or hospital care that a licensed doctor or dentist recommends.

This authorization shall remain effective until the following date, unless revoked sooner
in writing: ____________________________________________________________

(Date/day, and year)

Signature: ____________________________________________________________ Date/Time: ______________

(Parent, guardian, other person above having legal custody)

Print Name: __________________________________________________________

(Parent, guardian, person above having legal custody)

Witness to Signature: ____________________________ Date/Time: ______________

MINOR’S NAME: __________________________________________________________

_______ copy given to Agent _______ original placed in chart

initials initials

9/2011
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This form is for reference purposes only. It is a general guideline and not a statement of standard of care
and should be edited and amended to reflect policy requirements of your practice site(s), CMS and Joint
Commission requirements and legal requirements of your individual state(s).