

**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, or dental diagnosis or treatment, and hospital care which is recommended by, and to be 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 given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority to the above-named agent to give consent to any and all such diagnosis, treatment, or hospital care which a licensed doctor or dentist recommends.

These authorizations shall remain effective until \_\_\_\_\_, unless sooner revoked  
*(month, day, and year)*  
in writing.

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  
initials

\_\_\_\_\_ original placed in chart  
initials