AUTHORIZATION AND CONSENT FOR TREATMENT OF A MINOR CHILD (BY OTHER THAN GUARDIAN)

I, the undersigned 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 physician and sign any necessary waivers at Sunset Pediatrics in my absence:

____

(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 physician attending the child. I understand that I am responsible for settling any costs arising from this care provided in my absence.

This consent will remain in effect indefinitely unless otherwise noted here: ___________________________(Date to end consent)

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Parent or Legal Guardian Signature Date Print Name