AUTHORIZATION AND CONSENT FOR TREATMENT OF A MINOR CHILD

(**Other than primary and/or secondary guardian(s) – One form per child, please)

I, the undersigned parent, or legal guardian of ___________________________________Patient's Birth Date: _____ /_____/_____ authorize the following individual(s) to accompany my child, make decisions for treatment by a physician, and sign any necessary waivers at Sunset Pediatrics in my absence.

Last Name: ___________________________________ First Name: ____________________________ Middle Name: ___________________

Address: ____ Apt# __________ City: ________________ State ______ Zip ______________

Sex: ❑M ❑F Relationship to Patient: _____________________ Home Phone: (_____) ______-_______ Cell Phone: (_____) _______-_______

Last Name: ___________________________________ First Name: ____________________________ Middle Name: ___________________

Address: ____ Apt# __________ City: ________________ State ______ Zip ______________

Sex: ❑M ❑F Relationship to Patient: _____________________ Home Phone: (_____) ______-_______ Cell Phone: (_____) _______-_______

Last Name: ___________________________________ First Name: ____________________________ Middle Name: ___________________

Address: ____ Apt# __________ City: ________________ State ______ Zip ______________

Sex: ❑M ❑F Relationship to Patient: _____________________ Home Phone: (_____) ______-_______ Cell Phone: (_____) _______-_______

Last Name: ___________________________________ First Name: ____________________________ Middle Name: ___________________

Address: ____ Apt# __________ City: ________________ State ______ Zip ______________

Sex: ❑M ❑F Relationship to Patient: _____________________ Home Phone: (_____) ______-_______ Cell 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 setting any cost arising from this care provided in my absence.

This consent will remain in effect until the child is 18 years of age unless noted here: ______/______/______. (Date to end consent)

❑ I decline this consent to treat for my child for any person(s) other than the primary and/or secondary guardian(s).

(Please sign even if declining authorization)

____ Date: _____ /_____/_____

Signature Print Name and Relationship to Patient