Authorization to Consent to Treatment of a Minor

First Name _____ **Middle Name / MI** _____ **Last Name** _____

(I), (We), the undersigned, parent(s) of (minor named above), do hereby consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provision of the Medicine Practice Act on the Medical staff of Sanger Pediatrics, and such diagnosis or treatment is rendered at the office of said physician or at a hospital or a surgical center.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable.

Authorization effective until,
unless revoked in writing:

_____

Date

_____

Parent/Legal Guardian Signature: