Pensacola Pediatrics, P.A.

AUTHORIZATION CONSENT TO TREAT MINOR WITHOUT A PARENT OR LEGAL GUARDIAN

Child/ Minor Name: _____ DOB:_____

Child/ Minor Name: _____ DOB:_____

Child/ Minor Name: _____ DOB:_____

Child/ Minor Name: _____ DOB:_____

I, the undersigned, parent/person having legal custody/legal guardianship of the minor(s) named above, do hereby authorize

Name of agent _____ Relationship to patient _____

Name of agent _____ Relationship to patient _____

Name of agent _____ Relationship to patient _____

to act as my agent(s) to consent to any examination, anesthetic, medical or surgical diagnosis or treatment, and any other care which is deemed advisable by, and is to be rendered under the supervision of the Pensacola Pediatrics physicians whether such diagnosis or treatment is rendered at the physicians' offices or a hospital.

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 authority to the above described agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which a physician may, in the exercise of his/her best judgment, deem advisable.

I hereby authorize Pensacola Pediatrics which has provided treatment to surrender physical custody of such minor to the above-named agent(s) upon the completion of treatment.

These authorizations shall remain effective until (month and day) _____, 20_____ unless sooner revoked in writing delivered to the agent(s) noted above.

_____ _____

SIGNATURE (Parent or Legal Guardian) **Date**

_____ _____

PRINT NAME OF PARENT/LEGAL GUARADIAN **RELATIONSHIP to Patient**

Office Use Only

❑ **Telephone Consent Obtained by Practitioner**

2nd Witness **Signature** to Telephone Consent _____

Print Name and Title of 2nd Witness to Telephone Consent _____