AUTHORIZATION FOR THIRD PARTY TO CONSENT TO TREATMENT OF MINOR LACKING CAPACITY TO CONSENT

I am the ☐Parent
☐Guardian
☐Other person having legal custody; _____
(describe legal relationship)

of (name of minor), _____, a minor. I hereby authorize *(name of agent)* _____, to act as my 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.

This authorization is given pursuant to the provisions of Family Code Section 6910.

I hereby authorize any hospital providing treatment to the above-named minor pursuant to the provisions of Family Code Section 6910 to surrender physical custody of the minor to the above-named agent upon the completion of treatment. This authorization is given pursuant to Health and Safety Code Section 1283.

These authorizations shall remain effective until _____ / _____ / _____,
month day year
unless sooner revoked in writing delivered to the agent named above.

_____ _____/ _____/ _____ _____ AM / PM
Signature Date Time

_____ _____
Printed Name If signed by Legal Representative, relationship to patient

CHOC Children's
Children's Hospital of Orange County
1201 West La Veta Avenue
Orange, CA 92868-3874

PATIENT I.D.

998022 (6/2010)

MEDICALLY RELEVANT INFORMATION

Minor's Name: _____

Minor's date of birth: _____

Allergies to drugs or food: _____

Conditions for which minor is currently being treated: _____

_____

Current medications: _____

Restrictions on activity: _____

Name Primary Care Physician: _____

Telephone # of Primary Care Physician: (_____) _____ - _____

Insurance Company: _____

Mother's name: _____

Mother's address: _____

Mother's telephone numbers:

Home: (_____) _____ - _____

Work: (_____) _____ - _____

Other: (_____) _____ - _____

Father's name: _____

Father's address: _____

Father's telephone numbers:

Home: (_____) _____ - _____

Work: (_____) _____ - _____

Other: (_____) _____ - _____

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