

**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 xray examination, anesthetic, medical, surgical or dental diagnosis or treatment, which is recommended by, and to be rendered under the general or special supervision of, any licensed doctor or dentist, when such diagnosis or treatment is rendered at an outpatient surgery center.

I understand that this authorization is given in advance of any specific diagnosis, treatment, or 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 the Ambulatory Surgery Center to provide 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) _____

Date: _____

Signature: _____
(circle relationship: Parent/legal guardian/person having legal custody)

Signature: _____
(parent)