HURTT familyhealth CLINIC

Account Number: _____

DOB: _____

Medical Treatment Authorization (Minors)

AUTHORIZATION FOR AGENT TO CONSENT TO MEDICAL TREATMENT OF A MINOR

I hereby authorize _____ to consent to any x-ray, examination,
(Full name of an adult into whose care the minor has been entrusted)

immunizations, anesthetic, medical, dental, and mental health services, or surgical diagnosis or treatment and

hospital care of _____ deemed advisable by a license physician and surgeon and
(Full name of the minor)

provided by that physician or under that physician's supervision, regardless of where that treatment is provided.

This authorization is made under Family Code §6910.

This authorization supersedes any prior request for authorization to treat a minor submitted prior to the date below. It remains in effect until revoked in writing.

_____ _____
Signature (patient/legal representative) Date

If signed by someone other than patient, indicate relationship: _____

Print name: _____
(Patient/legal representative)