

AUTHORIZATION FOR 3RD PARTY MEDICAL RELEASE

I/we, the undersigned, parent(s) person(s) having legal custody/legal guardianship of _____, a minor, do hereby authorize _____ as agent (s) for the undersigned to consent to medical treatment, examination, surgical diagnosis, or 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 provisions of the Medical Practice Act on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said 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 power on the part of our aforesaid agent(s) to give specific consent to any all such diagnosis, treatment, or hospital care which a physician, meeting the requirements of this authorization, may in the exercise of his/her best judgment deem advisable.

I/we hereby authorize any hospital which has provided treatment to the above named minor to surrender physical custody of such minor to me/or above named agent(s) upon completion of treatment.

These authorizations shall remain effective until _____ 20___, unless sooner revoked in writing delivered to said agent(s).

_____ 20__

Signature of parent/legal guardian/person having legal custody

If signed by other than parent, indicate relationship _____.