Authorization for Care to Minor(s)

I/We, the undersigned parent(s) or legal guardian of the minor listed below:

Minor's Name: ____ Date of Birth: ____________________

do hereby authorize any medical diagnosis or treatment by any CareATC Provider (Physician, CNP, or PA) licensed in the State of ____ and services that may be rendered to said minor under the general, specific, or special consent of:

____ the temporary Custodian of minor.
(NAME OF ADULT PERSON WHO IS TEMPORARY CUSTODIAN OF MINOR)

I/We authorize the Provider to call in any necessary consultants, at their decision. We futher authorize said Provider to exercise their discretion in authorizing the disposal of any severed tissues or member.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required, but it is given to encourade those persons who have temporary custody of the minor, and said Provider to exercise their best judgement as to the requirements of such diagnosis or medical treatment.

This consent shall remain effective until ________ am/pm on the ________ day of __________________________ 20 ______ unless sooner revoked in writing, delivered to said Provider or said persons entrusted with custody, care, and control of said minor child.

Signature _______________________ Date _______________________

Relationship to Patient _______________________