

AUTHORIZATION FOR NON-PARENTAL ADULT CONSENT TO MEDICAL CARE AND TREATMENT OF MINOR

I, _____, am the biological or adoptive parent of _____,
born on _____.

I hereby authorize _____, to make all health care decisions pertaining to
my child, _____, including consent for all routine or ordinary medical care
and treatment, emergency medical care and treatment of any kind, and elective health care, including
elective surgical procedures, x-ray examinations or laboratory procedures, and the administration of
anesthesia.

Any health care provider relying upon this consent for the care and treatment of my child,
_____, may do so to the same extent and in the same manner as if I
had personally consented to such care or treatment.

This Authorization may be withdrawn only in writing, and shall not be deemed withdrawn until such
time as my child's health care providers receive actual notice that I have withdrawn my consent as
stated above.

- My child does not have any chronic diseases or drug allergies
- My child has a chronic disease or drug allergies. Explanation:

This authorization shall remain in effect until _____, or unless sooner withdrawn
in writing by the undersigned.

Date Parent or Legal Guardian's Signature

Relationship to Patient Witness Signature

Parent's or Legal Guardian's Address and Phone Number

Patient Identification - Always Attach Patient Label

Name:

MRN #:

CSN #:

Age / Sex and Gender:

NON-PARENTAL ADULT CONSENT FOR TREATMENT

MultiCare 

