Metropolitan Pediatric Specialists | An affiliate of Children's Hospitals and Clinics of Minnesota

Medical Authorization for Minors

I, _____, the parent of or legal guardian of

_____, a minor
Child(ren) Name and DOB

Do herby authorize the following people (names, phone numbers and relationship):

_____ _____

_____

_____

As agents for myself in my absence or incapacitation to consent to any medical or surgical diagnosis or treatment, x-ray examination and/or anesthetic medical care which is deemed advisable by and is to be rendered under the general or special supervision of any physician or surgeon licensed under the provisions of the Medical Practice Act at Metropolitan Pediatric Specialists, P.A.

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 and power on the part of the aforesaid agents to give specific consent to any and all such diagnosis, treatment or hospital care which aforementioned physician in the exercise of his or her best judgement may deem advisable.

These authorizations shall remain effective indefinitely or upon the written notice of the parent or legal guardian to cancel, change or amend them.

Signature of Parent or Legal Guardian:_____

Date: _____