UNITED INDIAN HEALTH SERVICES, INC.

Authorization for Third Party To Consent To Treatment Of Minor

***(Instructions:** This form is used to document those adults who have been entrusted to consent to medical or dental services for a minor who lacks the capacity to consent. This form may not be used for behavioral health unless services provided by a physician.)*

I am the

☐ Parent ☐ Legal Guardian ☐ Caregiver *(Caregiver Affidavit on file with UIHS)*

☐ Other Person having legal custody _____
(describe legal relationship)

of *(name of minor)*_____, *Birthdate:* _____

I hereby authorize the following adults to act as my agent to consent to any x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment, and hospital care which is recommended by, and to be rendered under the general or special supervision of, any licensed doctor or dentist, whether such diagnosis or treatment is rendered at UIHS or at a hospital.

I understand that this authorization is given in advance of any specific evaluation, diagnosis, treatment, or hospital care being required, but is given in to provide authority to the below named agent(s) to give consent to any and all such diagnosis, treatment, or hospital care which a licensed doctor or dentist recommends.

This authorization is given under the provisions of California Family Code Section 6910.

I hereby authorize any hospital providing treatment to the above named minor pursuant to the provisions of California Family Code Section 6910 to surrender physical custody of the minor to the below named agent(s) upon completion of treatment. This authorization is given pursuant to California Health and Safety Code Section 1283.

This authorization shall remain effective until _____, unless revoked in writing and delivered to the agent(s) named below.

Adults Authorized to Consent for Minor *(Name, contact information)*:

1. _____
2. _____
3. _____

Client Name _____ DOB _____ MRN_____

Print Name of Parent/Guardian: _____

_____ _____

Signature of Parent/Guardian Date

Client Name _____ DOB _____ MRN_____