



CONSENT FOR MEDICAL TREATMENT OF A MINOR

Patient Name: _____

Patient Account Number: _____

AUTHORIZATION

I, _____ am the parent/legal guardian of _____.

I hereby authorize **Temecula Valley OB/GYN Medical Associates, Inc.** to examine and treat _____, currently a minor, whose date of birth is ____/____/____.

I understand that any medical care has risks and benefits, but that these cannot be fully described here in anticipation of a potential for treatment.

This authorization is effective commencing on the _____ day of _____, 20____.

LIMITATIONS

Identify the type of medical services for which this authorization is given: _____

Identify the time frame for authorization. From _____ through _____.
(This consent will be valid for one year from date of signature unless stated differently)

I understand I may revoke this consent at any time, in writing, to: Temecula Valley OB/GYN Medical Associates, Inc., 25460 Medical Center Drive, Suite 100, Murrieta, California, 92562.

Name of Parent or Legal Guardian (PRINT)

Date

Signature of Parent or Legal Guardian

- Please specify relationship to minor:
- Parent with legal custody
 - Guardian with legal custody

“A Practice Specializing in Women’s Health Care”

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