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TEMECULA VALLEY OB/GYN MEDICAL ASSOCIATES, INC.

"A Practice Specializing in Women's Health Care"

AUTHORIZATION FOR AGENT TO CONSENT TO MEDICAL TREATMENT OF A MINOR

I hereby authorize ______________________________ (an adult into whose care the minor(s) has been entrusted) to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care of
____ (name(s) and address of minor(s)) deemed advisable by a licensed physician and surgeon and provided by that physician or under that physician's supervision, regardless of where that treatment is provided.

This authorization is made under Family Code §6910.

Signed: ____

Dated: ____

Print Name: ____

Please specify relationship to minor:

[ ] parent with legal custody

[ ] guardian with legal custody

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