Rose City Pediatrics Medical Group

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

(I),(We), the undersigned, parents of _____, a minor, do hereby consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is rendered under the general or special supervision of any physician or surgeon licensed under the provisions of the Medicine Practice Act on the Medical staff of Rose City Pediatrics Medical Group and such diagnosis or treatment at the office of said physician or at a hospital or at any other place.

It is understood that this authorization is giving in advance of any diagnosis, treatment or hospital care being required but is giving specific consent to any and all such diagnosis, treatment, or hospital care which the aforementioned physician in the exercise of his/her best judgment may deem advisable.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

This authorization shall remain effective until revoked in writing.

_____ _____

Signature of father/parent **Date**

_____

Printed name of father

_____ _____

Signature of mother/parent **Date**

_____

Printed name of mother

OR

_____ _____

Signature of Legal Guardian **Date**

_____

Printed name of Legal Guardian