MemorialCare

THIRD PARTY CONSENT FORM

Patient First Name	**Patient Last Name**
Patient Date of Birth	**Name of Parent/Legal Guardian/ Other Custody**

I am the

- ☐ Parent
- ☐ Legal Guardian
- ☐ Person Having Custody _____

(describe legal relationship_

of the above named patient.

I hereby authorize (name of agent) _____ to act as my agent to consent to treatment if I am not present.

Treatment may include, but is not limited to any: vaccine administration, 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 the doctors office or at a hospital. I understand that this authorization is given in advance or any specific diagnosis, treatment, or hospital care being required, but is given to provide authoirty to the above named agent to give consent to any and all such diagnosis, treatment, or hospital care which a licensed doctor or dentsist recomemnds. This authorization is given pursuant to the provision of Family Code Section 6910 and shall remain effective until (month/day/year) _____, unless revoked in writing.

_____ _____

Signature of Patient/Legal Guardian/ Other Custody Date