ADRIATICA
Women's Health
OB/GYN

AUTHORIZATION FOR THIRD PARTY TO CONSENT TO TREATMENT OF MINOR

MINOR'S NAME: ______________________________________ DOB: ____________________

I am the:
- ☐ **Parent**
- ☐ **Guardian**
- ☐ **Other person having legal custody ____**
  (Describe legal relationship)

I hereby authorize Adriatica Women's Health to act as my agent to consent to any X-ray examination, anesthetic, medical, surgical, dental diagnosis or treatment, and hospital care which is recommended by, and to be rendered under the general or special supervision of, any licensed physician, whether such diagnosis or treatment is rendered at the doctor's office or at a hospital.

I understand that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority to the above-named agent to give consent to any and all such diagnosis, treatment or hospital care which a licensed physician recommends.

This authorization is for today's services only. A separate authorization is required for each date of service.

Signature: ______________________________________ Date/Time: ___________/___________
(Parent, Guardian, other person above having legal custody)

Print Name: ____
(Parent, Guardian, other person above having legal custody)

Witness to Signature: __________________________________ Date/Time: ___________/_____