TRI STAR MEDICAL GROUP
Children's Specialists

PARENTAL DELEGATION OF RIGHT TO CONSENT TO TREATMENT OF A MINOR

My child's name is _____ who is _____ years of age.

My child's date of birth is _____.

My child's health record number is _____.

I authorize _____ to consent to the treatment of my child, when I am unavailable. His/her address is _____

_____

And his/her telephone number is _____.

I understand that this consent is given in advance of any specific diagnosis and such diagnosis may later require my specific informed consent before treatment can be provided.

This consent is valid for twelve (12) months from the date of my signature.

X _____ _____ / _____

Signature of Parent or Legal Guardian | Printed Name of Parent or Legal Guardian | Date/Time

_____

Relationship to Minor