Pediatric Surgical Associates, Ltd.

Medical Authorization for Non-Custodial Parents or Adults

Patient Name: _____ DOB:_____

Name of Legal Guardian: _____

Contact number of Legal Guardian:_____

As the parent or legal guardian of the patient indicated above, I hereby authorize the following person(s) as agents for myself in my absence or incapacitation to consent to any medical or surgical diagnosis or treatment, x-ray examination and/or medical care which is deemed advisable by and is to be rendered under the general or special supervision of any physician or surgeon licensed under the provisions of the Medical Practice Act at Pediatric Surgical Associates, Ltd. This form does not authorize the individual to consent to or schedule any surgical or other type of procedures on behalf of the patient and their legal guardian(s). Your signature acknowledges adherence of our Privacy Policy on behalf of the authorized agent(s).

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of the aforesaid agents to give specific consent to any and all such diagnosis, treatment or hospital care which aforementioned physician in the exercise of his or her best judgement may deem advisable.

Name(s), Phone Number, Relationship of Authorized Agents:

_____ _____ _____

_____ _____ _____

_____ _____ _____

I understand that these authorizations shall remain effective indefinitely or upon the written notice of the parent or legal guardian to cancel, change or amend them.

Signature of Parent or Legal Guardian: _____ Date: _____