Edward C. Olsgard, MD
Leo R. Leer, MD, FAAFP
Caroline L. Connor, MD, MPH
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Eureka Family Practice

Debra L. Barrow-Vrieze, FNP
Maureen Frank, FNP
John Brimlow, PA-C

An Incorporated Medical Group

AUTHORIZATION FOR TREATMENT OF A MINOR

(l)(We), the undersigned, parent(s) of ______________________________, a minor, do hereby authorize ______________________________ as agent(s) for the undersigned to consent to any X-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any physician and surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of arty specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which aforementioned physician .n 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.

(I)(We) hereby authorize any hospital which has provided treatment to the above-named minor pursuant to the provisions of Section 25.8 of the Civil Code of California to surrender physical custody of such minor to (my)(our) above-named agent(s) upon the completion of treatment. This authorization is given pursuant to Section 1283 of the Health and Safety Code of California.

These authorizations shall remain effective until ______________________, 20____, unless sooner revoked in writing delivered to said agent(s).

____

PARENT OR GUARDIAN DATE WITNESS

Address ____
Street City Zip Phone Number

MEDICAL HISTORY:

Child's Birthdate ______________________

Chronic Illnesses ______________________

____

Allergies ______________________

____

Last Tetanus ______________________

Medications (if long term) ______________________

____

____

____

Child's Doctor(s) ______________________

____

Child's Dentist ______________________

INSURANCE INFORMATION:
(The following would be helpful but **not** required)

Insured's Name ______________________

Name of Policy ______________________

Policy Number ______________________

Policy Holder's Name ______________________

Policy Holder's Occupation ______________________

Policy Holder's Work Phone ______________________

THIS AUTHORIZATION IS VALID FOR ONE YEAR FROM THE DATE WRITTEN ABOVE.

2675 Harris Street Eureka, CA 95503 Phone: (707) 443-8335 Fax: (707) 443-7327