PACIFIC CARDIOVASCULAR ASSOCIATES MEDICAL GROUP, INC.
A Professional Corporation

AUTHORIZATION FOR THIRD PARTY TO CONSENT TO TREATMENT OF MINOR LACKING CAPACITY TO CONSENT

I am the ☐ Parent

☐ Guardian

☐ Other person having legal custody _____
(describe legal relationship)

of (*name of minor*)_____, a minor.

I hereby authorize (name of agent) _____, to act as my agent to consent to any x-ray examination, anesthetic, medical, surgical diagnosis or treatment, and hospital care which is recommended by, and to be rendered under the general or special supervision of, any licensed doctor, 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 doctor recommends.

This authorization is given pursuant to the provisions of Family Code Section 6910.

I hereby authorize any hospital providing treatment to the above-named minor pursuant to the provisions of Family Code Section 6910 to surrender physical custody of the minor to the above-named agent upon the completion of treatment. This authorization is given pursuant to Health and Safety Code Section 1283.

This authorization shall remain effective until (*month and day*) _____, 20_____, unless sooner revoked in writing delivered to the agent named above.

Date: _____ Time: _____ AM/PM

Print Name: _____

Signature: _____