Authorization for Adult
(OTHER than parents or legal guardian)
to Consent for Treatment

Patient name: _____ Date of Birth: _____

I hereby authorize (list NAMES(s) and RELATIONSHIP):

_____

_____

As an adult into whose care the above minor(s) may be entrusted. He/she may consent to any examination and treatment that a licensed physician or nurse practitioner at DOC PAM, PA may deem advisable. This includes evaluation, procedures, medications, vaccines, and any other service that the provider deems is necessary in the treatment of my child.

I understand that my authorization will be effective starting from the date of my signature.

I understand that I may revoke this authorization at any time by written, dated communication.

I have read and understand the nature of this release and authorization.

Printed name: Date:

SIGNATURE: Relationship to patient(s):

DOC PAM, PA
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