PEACHWOOD MEDICAL GROUP
275 W. Herndon Ave.
Clovis, Ca. 93612

THIRD PARTY CONSENT AUTHORIZATION FOR MEDICAL TREATMENT

Child's Name: _____ DOB: _____

I hereby authorize the following adults:

_____ Relationship to minor: _____

_____ Relationship to minor: _____

_____ Relationship to minor: _____

_____ Relationship to minor: _____

To seek, obtain and consent to routine and emergency medical care and treatment, procedures and vaccinations for my child listed above as deemed necessary by a licensed medical or healthcare professional. This authorization is for the time period when my child is in the care of the person / people listed above. I may revoke or edit this consent at any time.

This authorization is under the Health Insurance Portability and Accountability Act of 1996.

Signed: _____ Date: _____

Print Name: _____ Relationship to Minor: _____

( ) This authorization is to be in effect from _____ to _____.

( ) This authorization is to remain in effect until revoked by the above signed.