Putnam North Family Medical Center
11220 N. Rockwell Ave.
Oklahoma City, OK 73162
405-722-9474

AUTHORIZATION FOR TREATMENT TO A MINOR

Minor's Name _____ **Date of Birth** _____

Minor's Social Security Number _____

I/we, the undersigned parent(s)/legal guardian(s), of the minor person listed above do authorize the physician's, physician's assistants or medical staff to provide health care services to this minor in the absence of a parent or legal guardian. The health service may include, but is not limited to: examination, preventative and/or curative treatment, x-ray, laboratory examination, anesthetic, medical or surgical diagnosis, and any consultation deemed necessary at the physician's / physician assistant's discretion. Services shall not include research or experimentation.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required and is given to encourage the physician / physician assistant to exercise his or her best judgement as to the requirements of such diagnosis or medical treatment in my/our absence.

I/we acknowledge that we are (I am) responsible for all charges in connection with care and treatment rendered.

This consent shall remain in effect until revoked, in writing, by parent(s) or legal guardian(s) or until child may legally consent for him or herself.

_____ _____
Signature – Parent or Legal Guardian **Date**

_____ _____
Signature – Parent or Legal Guardian **Date**