Edward C. Olsgard, MD
Leo R. Leer, MD, FAAFP
Caroline L. Connor, MD, MPH
Gregory Holst, MD

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