☐ Hoag Medical Group ☐ Hoag Urgent Care ☐ Hoag Physician Partners ☐ Hoag Concierge Medicine ☐ Hoag Specialty Clinic

CONSENT TO TREAT A MINOR

I, ______________________________ authorize the Hoag entity selected above and affiliates to provide medical care for ______________________________ (Patient Name) born on ________________ (Date of Birth) including immunizations, physical examinations, and testing/treatment for the purpose of medical diagnosis and treatment, which is deemed advisable by and is to be rendered by the providers and staff of the entity selected above and affiliates.

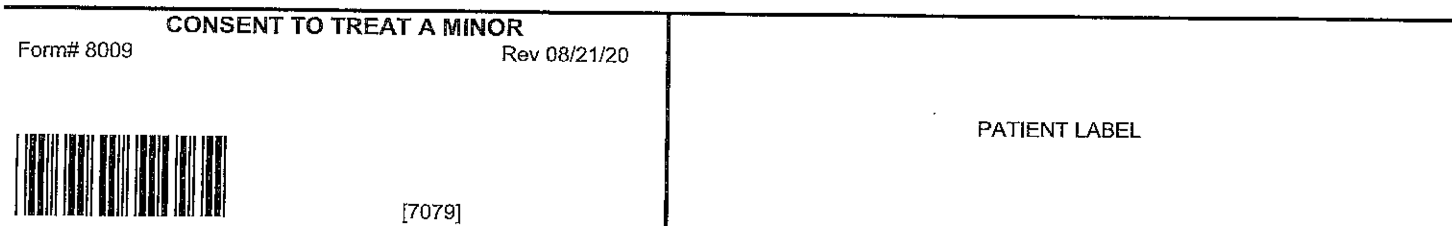
This authorization is effective as of ________________ (Date).

Parent/Legal Representative (Print Name): ____

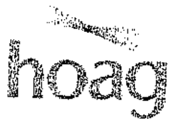
Parent/Legal Representative Signature: ________________________ Date/Time: __________

Witness: ____ Date/Time: __________

Note: Minors 12 years and older may consent to medical diagnosis, or treatment of the following: infectious or communicable diseases which must be reported to the local health officer; STDs, rape or HIV testing, mental health therapy or drug or alcohol related problems. Minors of any age may consent to medical diagnosis and/or treatment of the following: contraception, pregnancy, and diagnosis or treatment of sexual assault.



PATIENT LABEL



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AUTHORIZATION FOR THIRD PARTY TO CONSENT TO THE TREATMENT OF A MINOR

PATIENT LAST NAME (PLEASE PRINT) ______________________ PATIENT FIRST NAME (PLEASE PRINT) ______________________

DATE OF BIRTH ______________________ MRN ______________________

I, the undersigned, parent/legal guardian/person having legal custody of ______________ do hereby authorize ______________________ (List additional persons below) as agent(s) to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment which is deemed advisable by, and is to be rendered under the general or special supervision of licensed provider employed by the Hoag entity selected above and affiliates, when such diagnosis or treatment is rendered at the office of said provider.

It is understood that this authorization is given in advance of any specific diagnosis or treatment being required, but is given to provide authority to the above-named agent(s) to give specific consent to any and all such diagnosis or treatment which the provider, in the exercise of his/her best judgment may deem advisable.

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

This authorization shall remain effective until ____/____/20____, unless sooner revoked in writing.

PRINT NAME ______________________ SIGNATURE ______________________ DATE/TIME ______________________

Relationship to minor:

☐ Parent (If parents share medical decision-making authority, both parents must sign this form. If applicable, please see signature line below.)

☐ Legal Guardian

☐ Other person having legal custody. Describe legal relationship to minor:

____

***Additional authorized third parties list below:**

____

____

PATIENT LABEL