Health Central Women's Care

ADVANCE CONSENT TO PROVIDE MEDICAL TREATMENT FOR MINOR

I, ____ (name), hereby authorize and consent to medical treatment, either regular or emergency, of ____ (child's name), if such treatment is determined by a licensed physician of Health Central Women's Care to be necessary and I cannot be reached within a reasonable time, by reason of absence from the community or otherwise.

This authorization is given in advance of any specific medical diagnosis, treatment, or care being required, and is given to provide the licensed physicians of Health Central Women's Care the authority to perform or consent to any such medical diagnosis, treatment, or care, as our said agent and my child's attending physician, in the exercise of his or her best judgment, may deem advisable.

This authorization shall remain in effect until revoked by me in writing.

______________________________ ______________________________

Signature Relationship to Child

______________________________ ______________________________a.m. / p.m.

Date Time

Name of Child's Mother (if known): ______________________________

Name of Child's Father (if known): ______________________________

Name of Child's Guardian (if applicable): ______________________________