Comprehensive OB/GYN Minor Consent to Treat

I, _____, parent/legal guardian of _____,

a minor whose date of birth is _____, do hereby authorize **Comprehensive OB/GYN** and my daughter's assigned physician to evaluate and treat her on this _____ day of _____20____.

I understand the care being rendered will include medical evaluation as well as surgical evaluation if necessary, diagnostic testing which may consist of blood work sent to a third party testing facility, in office lab work and/or diagnostic imaging such as sonogram. I also authorize hospital admission if such treatment is necessary which may or may not require additional diagnostic imaging and/or anesthesia.

If I am not available to accompany my daughter to her scheduled appointment I have granted the following person authority and power to consent to the evaluation and treatment as listed above.

Name _____DOB _____ Phone # _____

If there are any questions or concerns I may be reached at _____.

It is understood this authorization is given in advance of any specific diagnosis, treatment or care being required, but is given to provide authority and power to render care which the aforementioned practice and established physician, in the exercise of his/her best judgment, may deem advisable.

I hereby indemnify and hold harmless **Comprehensive OB/GYN** and their physicians, officers, agents, employees, attorneys, directors, insurers, affiliates, subsidiaries, successors, and heirs from any and all liability for acting in reliance on this authorization. I also agree to accept financial responsibility for all care and services delivered pursuant to this authorization. This authorization also grants the power to release information to any third party payers who may be responsible for part or all of the cost of the services provided.

Signature of Parent or Legal Guardian _____ Date _____