California Rural Indian Health Board & Northwest Portland Indian Area Health Board
Board of Directors Joint Quarterly Board Meeting:
Youth Leadership Workshop
July 18-20, 2017

Authorization for Third Party to Consent to Treatment of Minor

Instructions: *This form is used to document those adults who have been entrusted to consent to medical or dental services for a minor who lacks the capacity to consent. This form may not be used for behavioral health unless services provided by a physician. Please complete by **June 23, 2017** and return to Daniel Domaguin at ddomaguin@CRIHB.org or fax to 916-263-0207.*

I am the

☐ Parent ☐ Legal Guardian ☐ Caregiver *(Caregiver Affidavit on file with CRIHB)*

☐ Other Person having legal custody ____
(Describe legal relationship)

of *(name of minor)*____, *Birthdate:* __________

I hereby authorize the following adults to act as my agent to consent to any x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment, and hospital care which is recommended by, and to be rendered under the general or special supervision of any licensed doctor or dentist, whether such diagnosis or treatment is rendered at the doctor's office or at a hospital.

I understand that this authorization is given in advance of any specific evaluation, diagnosis, treatment or hospital care being required, but is given to provide authority to the below named agent(s) to give consent to any and all such diagnosis, treatment, or hospital care which a licensed doctor or dentist recommends.

This authorization is given under the provisions of California Family Code Section 6910.

I hereby authorize any hospital providing treatment to the above named minor pursuant to the provisions of California Family Code Section 6910 to surrender physical custody of the minor to the below named agent(s) upon completion of treatment. This authorization is given pursuant to California Health and Safety Code Section 1283.

This authorization shall remain effective until _____________, unless revoked in writing and provided to a licensed doctor, dentist, or hospital.

Adults Authorized to Consent for Minor *(Name, contact information)*:

1. ____

2. ____

3. ____

Print Name of Parent/Guardian: ____

____ ________________
Signature of Parent/Guardian Date