AUTHORIZATION TO CONSENT TO TREATMENT OF UNEMANCIPATED MINOR (CHA FORM 9-1)

I (We), the undersigned, parent(s) or guardian(s) of ________________________,
a minor (Date of Birth______________) do hereby authorize:

Name: ___________________________________

Address: _________________________________

Phone: __________________________________

to act as agent for the undersigned to consent to medical, dental, emergency health and surgical care or treatment, including diagnostic tests, x-ray examination, anesthetic, and hospital care for the minor listed above, which is deemed advisable by, and is to be rendered under the general or special supervision of, a physician, whether such diagnosis or treatment is rendered at the office of said physician or at a health care facility.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but it is given to provide said agent with authority and power to give specific consent to any and all such medical, dental, emergency health and surgical care or treatment which said physician in the exercise of his or her best judgment may deem advisable.

This authorization gives a health care provider authority to release the above-named minor's medical information to the designated agent as necessary to allow the agent to make an informed decision regarding consent to treatment of the minor.

This authorization expires twelve (12) months after today's date: ________________________.

____
Father

____
Mother

____
Legal Guardian (if applicable)

____
Witness