Stanford MEDICINE Partners

Patient Label

Authorization for a Non-Custodial Caregiver to Consent to Treatment of a Minor

For unaccompanied minors:
I (We), the undersigned, parent(s)/legal guardian/person having legal custody of

_____, a minor, do hereby provide consent to the
(name of minor)
medical diagnosis, care and treatment of the aforementioned minor patient when he/she presents for care at Stanford Medicine Partners without the presence of a parent/legal guardian/person having legal custody.

OR

To designate authorized agents to accompany minor:

I,_____, am the
(legal guardian name)

- ○ Parent
- ○ Guardian
- ○ Other person with legal custody _____
(describe legal relationship)

of:_____, a minor. Date of Birth _____
(name of minor)

I hereby authorize: _____, and/or
(name)

_____, to act as my agent to
(name)

consent to any X-ray examination and/or medical diagnosis or treatment, and clinic care, which is recommended by, and to be rendered under the general or special supervision of, any licensed provider, where such diagnosis or treatment is rendered at the doctor's office.

I understand that this authorization is given in advance of any specific diagnosis, treatment, or clinic care being required, but is given to provide authority to the above- named agent to give consent to any, and all such diagnosis, treatment, or clinic care that a licensed provider or recommends.

I hereby authorize any clinic providing treatment to the above-named minor to surrender physical custody of the minor to the above-named agent upon the completion of treatment.

EXPIRATION: This authorization will automatically expire one (1) year from the date of execution unless a different end date is specified: _____
(insert date)
unless sooner revoked in writing delivered to the agent named above. Date: _____

Signature: _____