Medical Treatment Authorization and Consent

1.) I, _____ make oath and **declare** that I am the **parent or** lawful guardian of the child listed below and there are no court orders now in effect that would prohibit me from conferring the power to consent upon another person.

Information of Child

_____,born,_____ and residing at _____.

2.) I hereby authorize and appoint _____ as my agent (my "Agent"). Unless otherwise provided in this authorization my Agent may consent to emergency and routine medical treatment for my child, including dental treatment, anesthesia, and blood transfusion.

3.) My Agent may have access to any and all records, including, but not limited to, **health records, both written and digital**, and insurance records regarding any medical services or treatment provided.

4.) I give this consent freely and knowingly in order to provide for the child and not as a result of coercion, duress or payments by any person or agency.

5.) This consent will remain in effect until it is revoked by notifying my child's medical health care **provider or practitioner and the Agent named above, in writing**, that I wish to revoke it.
Any questions or concerns regarding this authorization may be directed to me at:

Name: _____
Address: _____
Phone Number: _____
Email: _____

Signature: _____

Notary Acknowledgement

STATE OF _____
COUNTY (OR CITY) OF_____ (SS)

On this day of _____, in the year _____, before me, the undersigned notary public, personally appeared _____, known to me to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged that he/she/they executed the same for the purpose therein contained. In witness whereof, I hereunto set my hand and official seal.

_____
Notary Public