



**Dean**  
CLINIC

## AUTHORIZATION FOR TREATMENT OF MINORS & INCOMPETENTS

(NOTE: Form can be used to allow minor or third party to consent without contacting parent/guardian)

I, the undersigned parent/guardian of \_\_\_\_\_,  
(minor's name and date of birth)

hereby empower and grant to \_\_\_\_\_  
(insert name of minor or third party)

permission to consent to and authorize medical and hospital treatment. This authorization is limited to  
treatment of the following medical condition(s) \_\_\_\_\_.

This authorization shall be valid for the period of time commencing on \_\_\_\_\_  
and ending \_\_\_\_\_. I do hereby indemnify and hold  
harmless the physicians, hospital and other persons who act in reliance upon this authorization.

Executed this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Parent/Guardian

### Information:

Parent/Guardian can be located at the following address/phone number: \_\_\_\_\_

Names/Addresses of family doctor, pediatrician, dentist: \_\_\_\_\_

Any known allergies: \_\_\_\_\_

### Insurance Information:

Company \_\_\_\_\_

Policy Number \_\_\_\_\_

Coverage Code \_\_\_\_\_