Los Robles Pediatric Medical Group, Inc.
299 W. Hillcrest Drive, Suite 100
Thousand Oaks, CA 91360
Telephone: (805) 497-7888
Fax: (805) 494-3498

Authorization for Parent or Legal Guardian to Consent to Medical Treatment of a Minor

I hereby authorize _____ to consent to any x-ray examination, anesthetic, medical/surgical diagnosis or treatment, age appropriate ACIP recommended vaccines and hospital care, regardless of where that treatment is provided for the following patients:

Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____

PLEASE NOTE THAT THE AUTHORIZED PERSON LISTED ABOVE MUST BE **18 YEARS OF AGE OR OLDER.**

This authorization is made under Family Code 6910. This Authorization will remain in affect unless further revoked.

Signed: _____ Dated _____

Print Name: _____

Please specify relationship to minor:

[ ] Parent with legal custody
[ ] Guardian with legal custody