Non-Parent Consent/Authorization for Treatment

This form allows for a someone other than a parent or guardian to authorize medical treatment. Please note that in an emergency that requires immediate intervention in order to save a life or prevent serious injury treatment will commence. Every reasonable effort will be made to contact you as soon as possible.

If the undersigned parent/guardian of _____ cannot be contacted through reasonable efforts, they do hereby empower and grant to:

Name: _____

Address_____

Phone: _____

-OR-

Name: _____

Address_____

Phone: _____

-OR-

Name: _____

Address_____

Phone: _____

The right to consent to any examination, laboratory test, radiologic procedure, hospitalization, or surgical procedure/anesthesia to be rendered to the above-named minor child under the supervision or advice of a physician/surgeon licensed to practice in the State of Alaska when need of such treatment is immediate and when efforts to contact me(us) are unsuccessful.

This authorization shall be valid until I provide revocation to Aurora Pediatrics in writing. I do hereby indemnify and hold harmless the physician, hospital or other persons who act in good faith upon this authorization.

Name Parent/Guardian_____

Signature_____ Date_____

Address_____

Phone_____ Alt Phone_____