Bedford Family Medicine, P.A.

1701 Forest Ridge Drive Bedford, Texas 76022 (817) 545-7700

# Non-Parental Authorization for Consent to Treat a Minor

I, _________________________, parent/legal guardian of the child(ren) listed below do hereby give my authorization and consent for the below named adult(s) to consent for the medical or surgical treatment of my child(ren). I hereby authorize and grant that the below named adult(s) has/have permission from the parents or legal guardian to obtain medical treatment or sign for surgical procedures deemed necessary for the health and well-being of my child(ren).

_____________________________ _____________________ ____________

Signature Relationship to child(ren) Date

Child(ren): ______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Authorized Person(s):

__________________________________ __________________________________

Name Relationship to Child(ren)

__________________________________ __________________________________

Name Relationship to Child(ren)

__________________________________ __________________________________

Name Relationship to Child(ren)

__________________________________ __________________________________

Name Relationship to Child(ren)

I understand that while this authorization may be rescinded at any time, it is my responsibility to communicate any changes to this consent in writing to **Bedford Family Medicine, PA.**

This authorization expires one year after the date it is signed and must be renewed yearly.