CAROLINA
NeuroSurgery & Spine
ASSOCIATES

AUTHORIZATION TO CONSENT TO HEALTH CARE FOR A MINOR

Name: _____ DOB: _____ MRN: _____

I, _____ , of _____ County, am the custodial parent having legal custody of _____, a minor child, age _____, born _ _____. I authorize _____, an adult in whose care the minor child has been entrusted, and who resides at _____, to do any acts which may be necessary or proper to provide for the health care of the minor child, including, but not limited to, the power (i) to provide for such health care at any hospital or other institution, or the employing of any physician, dentist, nurse, or other person whose services may be needed for such health care, and (ii) to consent to and authorize any health care, including administration of anesthesia, X-ray examination, performance for operations, and other procedures by physicians, dentists, and other medical personnel except the withholding or withdrawal of life sustaining procedures.

Optional: This consent shall be effective from the date of execution to and including _____

By signing here, I indicate that I have the understanding and capacity to communicate health care decisions and that I am fully informed as to the contents of this document and understand the full import of this grant of powers to the agent named herein.

_____ _____
Print Custodial Parent Date

_____ _____
Signature of Custodial Parent Date