DELEGATION OF PARENTAL AUTHORITY 
TO CONSENT FOR MEDICAL CARE OF MINOR

Instructions: Please print or type all information.

Name of child: 

Name(s) of parent(s) or guardian:
Address and telephone:

Health Insurance Carrier:
Policy number:
Consent authority delegated to:

The undersigned parent(s) hereby authorize the above-named person(s) to 
act as my/our agent and attorney-in-fact for the purpose of consenting to 
medical, dental, or hospital care and treatment of the named child. Such 
care and treatment is to be rendered by or under the supervision of a licensed 
practitioner, hospital or other health care facility. The agent is also 
authorized to have access to the health care history and records of the minor 
to the extent reasonably necessary to enable the agent to give informed 
consent for the minor's care and treatment.

Any health care practitioner or facility given an original or a photocopy of 
this document is authorized to honor the consent of the agent for care and 
treatment of the minor to the same extent as if consent were given by the 
parent(s) personally.

OPTIONAL: This delegation of authority terminates on _________________
20__.

_____________________________  ________________________________
Parent/Guardian signature    Parent/Guardian signature

Sworn to before me this _____ day of ________________________,
20__.

______________________________
Notary Public