Cone Health Medical Group

MRN_____

CONE HEALTH MEDICAL GROUP

AUTHORITY TO ACT FOR A MINOR REGARDING MEDICAL TREATMENT

I, _____, of _____ County, _____ (*state*), am the legal parent/guardian, whose rights have not been terminated, of _____, a minor child, age _____, born _____ (*mm/dd/yyyy*). I authorize _____, an adult in whose care the minor child has been entrusted, and who resides at _____ (street address), _____ (*city*), _____ (*state*), 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 of operations, and other procedures by physicians, dentists, and other medical personnel except the withholding or withdrawal of life sustaining procedures.

Limitations or Restrictions:

_____

This consent shall be effective from the date of execution to and including _____, 20____. 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 fully the import of this grant of powers to the agent named herein.

_____ _____

(Legal Parent/Guardian Signature) *(Date Signed)*

STATE OF NORTH CAROLINA **COUNTY OF** _____

On this _____ day of _____, 20____, personally appeared before me the named _____, to me known and known to me to be the person described in and who executed the foregoing instrument and he (or she) acknowledges that he (or she) executed the same and being duly sworn by me, made oath that the statements in the foregoing instrument are true.

Notary Public Name:_____

My Commission Expires: _____ _____

(Notary Public Signature / OFFICIAL SEAL)

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