

Peninsula Pediatric Medical Group, Inc.

AUTHORIZATION TO CONSENT TO MEDICAL TREATMENT OF A MINOR

I hereby authorize _____
(an adult into whose care the minor has been entrusted)
to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and
hospital care of

(name and address of minor)
deemed advisable by a licensed physician and surgeon and provided by that physician or under
that physician's supervision, regardless of where that treatment is provided.

This authorization is made under Family Code §6910.

Signed _____ Date _____

Print name _____

Please specify relationship to minor:

parent with legal custody

guardian with legal custody