CORNERSTONE
MEDICAL ASSOCIATES, LLC

Pediatric Associates

Authorization for Treatment of a Minor Lacking Capacity to Consent

This will authorize the physicians/physician assistants (PA)/nurse practitioners (NP) working under the practice of CORNERSTONE MEDICAL PEDIATRIC ASSOCIATES to provide medical care, including, examination, treatment, X-Ray examination, laboratory tests, local anesthetics, medical diagnosis and hospital care to _____, a minor.
(PATIENT NAME) (DOB)

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospitalization in order to avoid delay in providing such treatment as is deemed necessary by the aforementioned physician(s)/physician assistant(s)/nurse practitioner(s).

This authorization must be signed once a year to CORNERSTONE MEDICAL PEDIATRIC ASSOCIATES unless revoked sooner in writing. **Date Revoked:** _____

Date:	Signature of Parent/Legal Guardian	Print Name	Relationship other than parent
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