MEDICAL AUTHORIZATION FOR MINOR

I, ______________________________, the parent of ________________________________, a minor, do hereby authorize any one or more of ____, _________________________________, or __________________________________, as agents for myself in my absence or incapacitation to consent to any x-ray examination and anesthetic, medical or surgical diagnosis or treatment and medical care which is deemed advisable by and is to be rendered under the general or special supervision of any physician or surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any hospital whether or not such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but it is given to provide authority and power on the part of the aforesaid agents to give specific consent to any and all such diagnosis, treatment or hospital care which aforementioned physician in the exercise of his or her best judgement may deem advisable.

I hereby authorize any hospital which has provided treatment of the above-named minor to surrender physical custody of such minor to the above-named agents upon the completion of treatment.

These authorizations shall remain effective until ______________________, 2022.

State of FLORIDA **County of ____**

Sworn to (or affirmed) and subscribed before me this_____ day of ______, 202___. by ____ .

Notary Public (Print) ____

Notary Public (Sign) ____

Personally Known to me _______ **OR Produced Identification ______**

Type of Identification ____

My Commission Expires ____________________

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