Glenside Medical Associates, P.C.

4000A Glenside Drive
Richmond, VA 23228
(804) 262-4763
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AUTHORIZATION FOR CONSENT TO TREATMENT OF MINOR

(I)(WE), the undersigned, parent(s) or legal guardian of:

Patient Name: _____ SS#_____

Date of Birth:_____

a minor, do hereby authorize _____as agent(s) for the undersigned to consent to any x-ray, examination, anesthetic, medical or surgical diagnosis or treatment which is deemed advisable by and is to be rendered under the general or special supervision of any licensed physician and/or the medical staff of Glenside Medical Associates, P.C..

It is understood that this authorization is given in advance of any specific diagnosis or treatment being required but is given to provide authority and power on the part if our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment which the aforementioned physician in the exercise of his/her best judgment may deem advisable.

This authorization shall remain in effect until_____,20____ unless sooner revoked in writing delivered to said agent(s).

Date:_____Parent:_____

Legal Guardian:_____

Father/Guardian Home Phone # Business Phone #

Mother/Guardian Home Phone # Business Phone #

Child's Doctor: _____ Doctor's Phone #_____