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Authorization for a Non-Custodial Caregiver to Consent to Treatment of a Minor

For unaccompanied minors: I (We), the undersigned, parent(s)/	/legal guardian/person having legal custody of
	, a minor, do hereby provide consent to the
(name of minor) medical diagnosis, care and treatm presents for care at University Hea guardian/person having legal custo	ment of the aforementioned minor patient when he/she althCare Alliance without the presence of a parent/legal
To designate authorized agents (legal guardian name)	to accompany minor:, am the
ParentGuardian	
GuardianOther person with legal custody	V
o duiei person mar iogar castoa.	(describe legal relationship)
of:	, a minor. Date of Birth
I hereby authorize:	, and/o
	(name)
	, to act as my agent t
(name	
which is recommended by, and to	and/or medical diagnosis or treatment, and clinic care, be rendered under the general or special supervision of diagnosis or treatment is rendered at the doctor's office
or clinic care being required, but is	n is given in advance of any specific diagnosis, treatmen s given to provide authority to the above- named agent th diagnosis, treatment, or clinic care that a licensed
	ding treatment to the above-named minor to surrender ne above-named agent upon the completion of
EXPIRATION: This authorization veceution unless a different end date.	will automatically expire one (1) year from the date of ate is specified:
unless sooner revoked in writing d	(insert date) delivered to the agent named above.
Date:	

University HealthCare Alliance ("UHA") is a medical foundation affiliated with Stanford HealthCare and Stanford medicine. UHA contracts with several physician groups to provide the medical care in the UHA clinics. Neither UHA, Stanford HealthCare nor Stanford University employ the physicians in the clinics and do not exercise control over the professional services provided by the physician group.