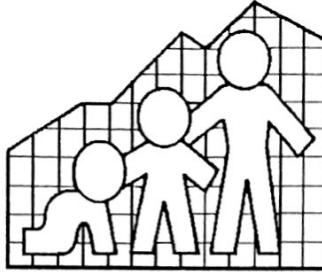

HENDERSONVILLE PEDIATRICS, P.A.

Authorization to Consent to Heath Care for Minor

I, ________________________________ of ___________________ County, State of ______________________, am the custodial parent having legal custody of ____________________________, a minor child, and age _____, born on _________. I authorize the physicians and staff of Hendersonville Pediatrics of ______________ County, State of North Carolina, to do any acts which may be necessary or proper to provide for the heath care of the minor child, including, but not limited to, the owner to provide such health care at any hospital or other institution, or the employing of any physician, dentist, nurse, or other person whose services may be needed for such health care, and to consent to and authorize any performance of operations, and other procedures by physicians, dentist, and other medical personnel, except the withholding or withdrawal of life sustaining procedures.

This consent shall be effective for the date it is executed until the date I terminate it in writing. By signing here, I indicate that I have the understanding and capacity to recognize the importance of, to communicate, and do assign the heath care decisions covered by this document. (ii) I am fully informed as to the contents of the document, and (iii) I understand the full scope and importance of this grant to powers to the agent named herein.

____

Custodial Parent or Guardian's Signature Date