POWER OF ATTORNEY
AUTHORIZATING THIRD PARTY
to consent to treatment of minor lacking capacity to consent

I/we, the undersigned, parent (s)/person having legal custody/legal guardian of _____(patient) DOB:_____, a minor, do hereby authorize _____

_____

_____

as agent (s) for the undersigned to discuss and to consent to medical care, diagnosis and treatment which is deemed advisable by, and is to be rendered under the general or special supervision of any physician licensed under the provisions of the Florida Medical Practice Act on the medical staff of Beaches Pediatrics, PA. I acknowledge that I have also signed a HIPAA Authorization so that the aforesaid agent may receive medical information about the patient.

It is understood that this authorization may be given in advance of any specific diagnosis, treatment, or hospital care being required but is given to authorize aforesaid agent (s) to give specific consent to any and all such diagnosis, treatment or hospital care which a physician, meeting the requirements of this authorization, may in the exercise of his/her best judgment deem necessary and appropriate.

This authorization shall remain effective until _____, 20____, unless sooner revoked in writing delivered to Beaches Pediatrics, PA.

_____ dated _____, 20_____.
Signature of parent/legal guardian / person having legal custody

_____ _____
Witness 1 signature Witness 2 signature

_____ _____
Witness 1 written name Witness 2 written name

If signed by person other than parent, indicate relationship to the Patient:

_____.

POWER OF ATTORNEY
AUTHORIZATING THIRD PARTY

Minor's name: _____ DOB: _____
Notary Public:
State of Florida, Duval County
This foregoing instrument was acknowledge before me on this _____ day of _____, 20____, by _____

Who is personally known to me or who has produced _____ identification.

_____. Stamped Commission
Signature of Notary Public