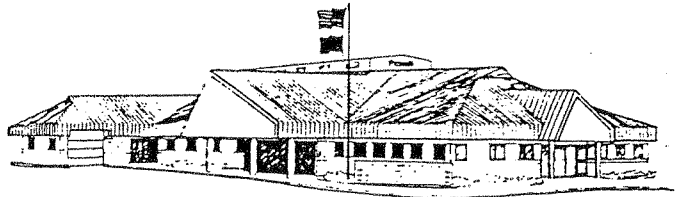


CORDOVA
COMMUNITY
MEDICAL
CENTER



P.O. Box 160 • 602 Chase Ave. • Cordova, Alaska 99574-0160
Phone: (907) 424-8000 • Fax: (907) 424-8116

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR

I/We, the parent(s) of _____, minor(s),
do hereby authorize _____, as agent(s) for
the medical or surgical diagnosis or care which is deemed advisable
by and is to be rendered under the general or specific supervision
of any physician or surgeon licensed and on the medical staff of
Cordova Community Medical Center, whether diagnosis or treatment is
rendered at the office of the physician or at the hospital. It is
understood that this authorization is given in advance of any
specific diagnosis, treatment or hospital care being required, but
is given to provide authority and power on the part of the above
named agent(s) for care as may be necessary in our absence.

This authorization shall remain effective until
_____, unless sooner revoked in writing
(day) (month) (year)
delivered to above agent(s).

Please list any known allergies for above minor(s):

Witness

Signature of Father

Witness

Signature of Mother

DATE

Signature of Agent