Cordova Community
MEDICAL CENTER

P: (907) 424-8000 | F: (907) 424-8116
P.O. Box 160 | 602 Chase Ave., Cordova, AK 99574-0160

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR

I/We, the parent (s) of _____, minor(s), do hereby authorize _____, as agent(s) for this 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 name agent(s) for care as may be necessary in our absence.

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

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

_____ _____
Witness Signature of Father

_____ _____
Witness Signature of Mother

_____ _____
Date Signature of Agent