BOONE DERMATOLOGY CLINIC, P.A.

AUTHORIZATION TO CONSENT TO HEALTH CARE FOR MINOR

I, _____, of _____ County, State of _____,

am the custodial parent having legal custody of _____, a minor child, age _____, born on _____

_____, in _____ County, State of _____, give my permission to provide services which may be medically necessary or proper to provide for the health care of the minor child, including, but not limited to, the power to provide for 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 health care, including administration of anesthesia, X-ray examination, performance of operations, and other procedures by physicians, dentists, and other medical personnel, except the withholding or withdrawal of life-sustaining procedures.

This consent shall be effective from 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 to assign the health care decisions covered by this document, I am fully informed as to the contents of the document, and I understand the full scope and importance of this grant of powers to the agent named herein.

_____ _____

Custodial Parent's Signature Date

_____ _____

Witness Date

_____ _____

Witness Date

(8/2019)