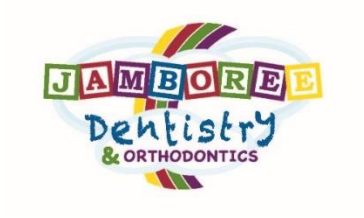

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

I, _____ [name], am the _____ [parent/guardian/managing conservator] of _____ [name of minor], a minor child, and have the power to consent to medical treatment for [him/her]. _____ [name(s)] [is/are] _____'s [name of minor] other parent(s). I authorize and appoint _____ [name] as my agent to consent to medical treatment of the minor, such medical treatment to include, without limitation, X-ray examination; anesthetic treatment; medical, dental, or surgical examination or treatment; and general hospital care. No prior determination of life-threatening emergency or danger of serious or permanent injury resulting from delay of treatment need be made under this authorization.

I will indemnify and hold harmless from any expense or claim of any nature any entity that provides or causes to be provided examination, treatment, or hospital care under this authorization (except to the extent such entity is negligent therein) and agree to make or cause to be made, by assignment of third-party benefits or otherwise, full and complete payment for such examination, treatment, or hospital care.

SIGNED on _____.

_____

Name:

[Parent/Guardian/Managing Conservator]

PLEASE NOTE THIS CONSENT DOES NOT APPLY TO PROCEDURES PLANNED WITH ORAL CONSCIOUS SEDATION AND/OR GENERAL ANESTHESIA. A PARENT OR GUARDIAN MUST BE PRESENT AND REMAIN IN THE OFFICE FOR THE ENTIRE PROCEDURE IF ORAL SEDATION OR GENERAL ANESTHESIA ARE UTILIZED