AUTHORIZATION FOR OTHER THAN A PARENT OR GUARDIAN TO CONSENT FOR TREATMENT OF A MINOR CHILD

I _____ do hereby state that I am the parent/guardian having legal

custody of _____, a minor, born _____ who resides
(minor's name) (birthdate)

with me at:

_____.
(address, city, state)

I authorize _____ of _____
(appointed responsible adult) (city, state)

to consent to any x-ray examination, anesthetic, medical, dental or surgical treatment, hospital care, and mental health treatment to be rendered to the minor under consent of the appointed responsible adult of the minor and on the advice of the licensed professional in the state of Michigan.

The consent shall remain effective unless revoked in writing.

Dated this _____day of _____, _____
(date) (month) (year)

_____
(signature of parent or guardian)

_____
(witness)

Additional adults authorized to bring my child to Mott Children's Health Center:

Date	Parent's Signed Initial	Name of Authorized Adult (please print)	Relationship to Child/Adolescent	Date and sign here ONLY when removing authorization