Consent for Treatment of Minors

I, the undersigned parent/guardian of _____,
(Patient Name)

In the event that I cannot be contacted through reasonable efforts or we are unable to accompany the above mentioned patient /ward, hereby empower and grant to UROHealth Partners, permission to, consent to and authorize medical treatment for the above name child/ward. This authorization shall be valid for the period of time beginning on _____ and ending _____**.** (*Child will be accompanied by _____)

I do here by indemnify and hold harmless the physicians, hospital and other persons who act in reliance upon this authorization.

Executed this _____day of _____, 20____.

Parent/Guardian _____verbal consent

Witness_____

Parent/Guardian can be located at the following address or phone number: _____