**JOHN C. CHIU, M.D.**
FAMILY PRACTICE
100 LOS GATOS SARATOGA ROAD, SUITE B
LOS GATOS, CA 95032
(408) 863-0709

# AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR WITHOUT THE PRESENCE OF FAMILY MEMBER

(I) (We), the undersigned, parents(s)/legal guardian of _____,

a minor, do hereby authorize _____ to be evaluated by John C. Chiu for his/her medical complaint, and consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of John C. Chiu, M.D., whether such diagnosis or treatment is rendered at the office of said physician or 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 to the above described agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

This authorization shall remain effective until _____, 20 _____, unless sooner revoked in writing delivered to the agent(s) noted above.

Dated _____

Father _____

Mother_____

Legal Guardian _____