**AUTHORIZATION FOR**

#  CONSENT TO MEDICAL TREATMENT OF MINOR

 I, \_\_\_, being the parent entitled to the legal and physical custody of my minor child, ­­­­­­, born ­­­­­­­­­­­, 2016, do hereby authorize \_\_\_\_\_ to consent to any X-ray, examination, anesthetic, medical or surgical diagnosis or treatment and hospital care to be rendered to said minor child under the supervision and upon the advice of a physician or other medical care provider licensed to practice medicine in any state in the United States. I further authorize ­­­----- to consent to any mental or behavioral health care or treatment to be rendered to said minor child by a professional licensed in any state in the United States. I further authorize \_\_\_\_\_\_ to consent to any dental treatment to be rendered to said minor child by a dentist licensed to practice dentistry in any state in the United States.

 This shall be valid until further notice.

 DATED: \_\_\_\_\_\_, 2016, at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, WA.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STATE OF WASHINGTON )

 ) ss.

County of King )

 On \_\_\_\_\_\_, 2016, before me, a Notary Public for the State of Washington, personally appeared \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, known to me to be the person whose name is subscribed to within the AUTHORIZATION FOR CONSENT TO MEDICAL TREATMENT OF MINOR and acknowledged that she executed the same.

 WITNESS my hand and official seal.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­

 NOTARY PUBLIC in and for the State of

 Washington, residing at Seattle

 Commission Expires: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_