PENDLETON
Community Care, Inc.

# AUTHORIZATION FOR NON-PARENTAL CONSENT FOR MEDICAL TREATENT OF A MINOR

I, _____, a resident of _____, _____ County,
(Print Full Name of Parent/Legal Guardian) (Print City) (Print County)

_____, do hereby state that I am the parent or legal guardian of: _____,
(State) (Print Minor's Full Name)

a minor, born on _____, who resides with me at:
(Print Minor's Date of Birth)

_____.
(Print Street Address, City, State, and Zip Code)

With this form, I do hereby state that I have full/shared legal custody of the aforementioned Minor and have the authority to consent for all medical/surgical care and treatment of said Minor.

I, parent/guardian of the minor child listed above, do hereby give my authorization and consent to allow:

_____, an adult over 18 years of age, who resides at:
(Print Name of Non-Parent Authorized to Consent)

_____,
(Print Street Address, City, State, and Zip Code)

to consent to the medical/surgical care and treatment of my child. I hereby authorize and grant that the above named person has/have permission from the natural parents to consent to any routine or necessary examination, anesthetic, medical diagnosis, surgery or treatment, and/or hospital care to be rendered to the above-named minor under the general or special supervision and on the advice of any physician, surgeon, or medical provider, licensed to practice medicine in the state where said minor is seeking treatment, beginning on: _____.
(Print Date)

I agree to assume financial responsibility for all expenses billed in association with such medical care.

Choose One of the Following:

☐ This Authorization is indefinite and shall remain in effect until I terminate it in writing.
OR

☐ This Authorization shall automatically terminate on _____.
(Print Date)

**Parent/Guardian Signature: _____ Date: _____**

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**STATE OF WEST VIRGINIA,**
**COUNTY OF _____, TO-WIT:**

Taken, subscribed, and sworn to before me on the ____ day of _____, 20____.

My Commission expires: _____.

(Seal)

_____
**NOTARY PUBLIC**