Austin Pediatric Surgery
A surgical specialty of Dell Children's Medical Center

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Consent for Treatment in Absence of Legal Guardian

Date: _____

I, _____, as the legal guardian of patient _____,
(Guardian's Name) (Pt. name)

date of birth _____, do hereby give permission to _____
(Responsible Party)

to make any medical/legal decision for evaluation and treatment by the providers of Austin Pediatric Surgery.

This permission/authorization during my absence is only for this specific date of service_____.

_____
Parent Signature

_____
Signature of Responsible Party