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

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Consent to Treatment in Absence of Legal Guardian

Date: ______________________________

I, _______________________, as the legal guardian of patient ____________________,
(Parent/Guardian name) (Patient)

Date of Birth _____________, do hereby give permission to _____________________,
(Responsible Party)

To make any medical/legal decisions 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:

____
(Date)

____
Parent/Guardian Signature

____
Signature of Responsible Party

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