Luisa Carrasquero, MD, FAAP

AUTHORIZATION TO TREAT MINOR

(I)(We), the undersigned, parent(s) of ________________________, a minor, do hereby

Authorize **Wekiva Springs Pediatrics** as agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment which is deemed advisable by, and is to be rendered under the general or special supervision of, any physician who works there, whether such diagnosis or treatment is rendered at the office of said physician.

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 and power on the part of our aforesaid agent(s) to give specific consent to any and all such medical or surgical diagnosis or treatment which the aforementioned physician in the exercise of his or her best judgment may deem advisable.

This authorization is effective _______________, 20__, and shall remain effective indefinitely unless sooner revoked in writing delivered to said agent(s)

Date: _________________________

Parent ____

Parent ____

Legal Guardian ____

Witness _________________________________ Date ____________________

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