

## CONSENT FOR TREATMENT BY PARENT FOR MINOR

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## CONSENT FOR TREATMENT UNDER GUARDIANSHIP

prevention    diagnosis    treatment    surgery    [www.gispecialistsmemphis.com](http://www.gispecialistsmemphis.com)

Patient Name: \_\_\_\_\_

Patient Age (if minor) \_\_\_\_\_

I, \_\_\_\_\_ hereby authorize the physicians of Gastrointestinal Specialists, P.C. to provide such medical services including surgery, if necessary, either scheduled or emergency as may be determined to be in the best interest of patient, \_\_\_\_\_.

This authorization shall continue and be effective until revoked in writing by me.

A photocopy of this authorization shall be considered as effective and valid as the original.

Signature of Parent \_\_\_\_\_ Date \_\_\_\_\_

Signature of Patient Representative \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Date \_\_\_\_\_