Jeffrey R. Horwitz, MD
Michael D. Josephs, MD
Tory A. Meyer, MD
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Austin Pediatric Surgery

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

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