Aspen Children's Clinic of Broken Arrow

Suresh Bharani M.D.

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Authorization to Treat Minors

I hereby give permission the person/s listed below to authorize any x-ray examination, anesthetic, Dental, medical or surgical diagnosis or treatment by any physician licensed by the state of Oklahoma, and hospital service that may be rendered to said minor under the general, specific or special consent of person/s listed below whether such diagnosis is rendered at the office of the physician or at a hospital licensed by the state of Oklahoma. I authorize the physician to call in any necessary consultants, in their discretion.

Name: _____ **Birth Date**: _____

Relationship to Patient: _____

Name: _____ **Birth Date**: _____

Relationship to Patient: _____

Name: _____ **Birth Date**: _____

Relationship to Patient: _____

It is understood that this consent is given in advance of any specific diagnosis or treatment being required and said physician is to exercise their best judgment as to the requirements of such diagnosis, medical or surgical procedure.

***This consent shall remain in effect until the _____day of _____, 20___.**

Unless revoked in writing. Delivered to said physician, or said persons entrusted with the Custody and control of said child.

Parent/Legal Guardian Name: _____ **Date**: _____

Relationship to Patient: _____

Parent/Legal Guardian Signature: _____ **Witness**: _____