HEALTH CARE AUTHORIZATION & CONSENT FOR TREATMENT OF MINORS

I, _____ *(insert name of natural or adoptive parent, or legal guardian of minor patient)*, as the natural or adoptive parent or legal guardian of minor patient named below, have legal authority to and give authorization and consent to Baptist Health System, Inc., its subsidiaries, and their respective physicians, nurses and other health care practitioners and staff ("Baptist Health Providers"), to provide, solicit, or arrange to provide, health care services and treatment to _____ *(insert name of minor patient)*, whose date of birth is: _____ . I understand that health care services and treatment may include the use of x-rays, scans, laboratory tests, prescription medications, administration of medications and vaccines, records of the minor patient's blood or DNA, and other diagnostic procedures and tests typically provided in a health care setting.

I further give authorization and consent to Baptist Health Providers to create, store, or share records of the named minor patient's blood or deoxyribonucleiuc acid (DNA).

I further give authorization and consent to Baptist Health Providers to provide, solicit, or arrange to provide health care services and treatment to the named minor patient when they are accompanied by the following individuals in my absence (or any other individual permitted by law):

_____
Name of Authorized Individual and Relationship to Minor Patient

_____
Name of Authorized Individual and Relationship to Minor Patient

_____
Name of Authorized Individual and Relationship to Minor Patient

_____
Name of Authorized Individual and Relationship to Minor Patient

This authorization and consent is valid for one year, unless revoked by me.
I understand the above statements and that I may revoke this authorization at any time.

_____
Print name of natural or adoptive parent, or legal guardian of patient

_____
Signature Date Time