CONTINUING CONSENT TO TREATMENT
AND
AUTHORIZATION TO RELEASE INFORMATION

We, the undersigned parent(s) or guardian(s) of _____, a minor, do
Minor's Name
hereby consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital service that may be rendered to said minor under the general or specific instructions of _____M.D., or any physician the organization specified in the
Name of Physician

following paragraph may call, whether such diagnosis or treatment is rendered at the office of said physician or at a licensed hospital. It is understood that reasonable effort will be made to contact the doctor listed above before any other physician is called by the organization. It is further understood that this consent is given in advance of any specific diagnosis or treatment which might be required and is given to authorize

_____ or the _____

to exercise their best judgment as to the requirements of such diagnosis or treatment.

This consent shall remain in continuous effect until revoked in writing and delivered to the physician named above or to the organization entrusted with the custody of said minor.

We hereby authorize any hospital, physician, or other person who has attended or examined the minor to furnish to the Indiana Conference Health Care, or its representative, any and all information with respect to any illness, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photo static copy of this authorization shall be considered as effective and valid as the original.

On the reverse side of this consent is a description of the minor's health concerns known to the parent or guardian which should be considered when diagnosing or rendering treatment.

Dated:_____

Home Phone Number: _____

Emergency Phone Numbers: _____ or _____

_____ _____

_____ _____

Father's Name *Mother's Name*

_____

Legal Guardian