Infinity
Pediatric & Adolescent Medicine

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Phone: 757-780-8400
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Consent To Treat Minor

I hereby give consent to Infinity Pediatric & Adolescent Medicine to perform any radiology or lab testing, examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care as deemed advisable by a licensed physician, nurse practitioner or physician assistant, as well as any assistant on the staff of Infinity Pediatric & Adolescent Medicine.

I understand that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required.

This consent is given to any and all such diagnoses, treatments and hospital care which a licensed physician at Infinity Pediatric & Adolescent Medicine recommends.

This authorization will remain in effect until revoked in writing by the parent or legal guardian.

Signed: _____

Print Name: _____

Date: _____

Please specify relationship to minor:

- ☐ Parent with legal custody
- ☐ Guardian with legal custody