AUTHORIZATION FOR DBH STAFF TO ARRANGE/PROVIDE MEDICAL CARE AS NECESSARY FOR A MINOR CLIENT

1. I (We), the undersigned, regarding _____, a minor, do hereby authorize the Director of San Bernardino County Department of Behavioral Health, or his designated agent(s), to consent to any X-ray examination, anesthetic, medical, or surgical diagnosis or treatment, hospital care, mental health treatment, or counseling (as described in California Civil Code Sections 25.8 and 25.9), to be rendered to the minor under the general or special supervision of, and upon the advice of, a physician, surgeon, and/or psychiatrist licensed under the provisions of the Medical Practice Act, or to consent to an X-ray examination, anesthetic, dental, or surgical diagnosis or treatment and hospital care to be rendered to the minor by a dentist licensed under the provisions of the Dental Practice Act, whether such diagnosis or treatment is rendered at the office of said physician, psychiatrist, or dentist or at said hospital. Administration of immunizing vaccines is also authorized.

2. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which the aforementioned medical professionals in the exercise of their best judgment may deem advisable.

3. This authorization is given pursuant to provisions of Sections 25.8, and 25.9 of the Civil Code of California.

4. This authorization shall remain effective from _____ to _____, unless sooner revoked in writing and delivered to said agent(s).

_____
Other insurance carrier for minor (policy number)

_____
Medi-Cal coverage for minor (card number)

_____
Father Date

_____
Mother Date

_____
Legal Guardian* Date

_____
Social Worker authorized to consent Date

_____
Witness Title Date

*****NOTE: Legal Guardian must attach a photocopy of documentation of legal custody.

MEDICAL CARE AUTHORIZATION FOR MINOR
San Bernardino County
DEPARTMENT OF BEHAVIORAL HEALTH
Confidential Patient Information
See W&I Code 5328

NAME:

CHART NO:

DOB:

PROGRAM: