IDAHO
UROLOGIC
INSTITUTE

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Authorization for Treatment of Minors

I, the undersigned parent/guardian of _____,
(Minor's name and date of birth)

hereby empower and grant to _____
(Name of third party)

permission to consent to and authorize medical treatment. This authorization is limited to treatment for the following medical condition(s) _____.

This authorization shall be valid for the period of time commencing on _____ and ending _____.

I hereby release and hold harmless IUI and its providers from all liability for their reliance on this authorization and consent to treat my minor child.

_____ _____
Parent/Guardian Date Witness Date