

CATSKILL REGIONAL MEDICAL CENTER
Harris, NY 12742
Calicoon, NY 12723

Authorization to consent to the treatment of minors temporarily separated from parents:

I, the undersigned parent/guardian of _____, a minor, do hereby authorize **CAMP HAZE** as our agent(s) to consent to any diagnostic procedures or medical care which is deemed advisable by, and is rendered under the general or special supervision of, any licensed physician and surgeon at **Catskill Regional Medical Center**, when such diagnosis or treatment is rendered at said hospital. It is understood that this authorization is given in advance of any specific need for treatment but is given to provide authority on the part of the aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the physician, in the exercise of his/her best judgment may deem advisable. This authorization shall remain effective until August 21, 2011 unless sooner revoked in writing delivered to said agent(s).

Parent/Guardian's Signature _____

Date _____ Telephone number _____

Permanent Address _____

Temporary Address: _____

NOTE: This document must be made part of the patient's medical record.