(949) 951-KIDS (5437)

Fax (949) 951-2715

Sea View Pediatric Medical Associates, Inc.

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR

(I) (We), the undersigned parent(s)/guardian(s) to:____________________ a minor, do hereby authorize Sea View Pediatric Medical Associates, Inc. as agent for the undersigned to consent to any examination, medical diagnoses or treatment which is deemed advisable and is to be rendered at the office.

The authorized is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

______________________________	______________________________
Parent or Guardian (Print)	Parent or Guardian (Signature)
______________________________	______________________________
Sea View Pediatrics Witness	Date