TEMPLETON IMAGING, Inc.
262 Posada Lane, Suite C
Templeton, CA 93465

Selma Carlson Diagnostic Center
77 Casa Street, Suite 102
San Luis Obispo, CA 93405

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

(I) (We) the undersigned parent(s) of ______________________________, a minor, do herby authorize Templeton Imaging, Inc. for the undersigned to consent to have the exams requested by the minor's physician. The exams may include ultrasound, MRI, CT, Fluoroscopic exams and X-Rays, medical or surgical diagnosis

or treatment, or hospital care that is deemed advisable by, and is to be rendered under the general or special supervision of, any physician and /or surgeon licensed under the provisions of the Medical Practices Act.

It is understood that this authorization is given in advance of any specific diagnosis treatment, care or examination as ordered by the minor's physician. I consent of any and all such diagnosis, treatment, or hospital care that aforementioned physician in the exercise of his or her best judgment, may deem advisable. This authorization is given pursuant to the provisions of California Family Code ~6910.

I grant authority to the following to be my legally authorized representative(s) in the medical care of my child. He or she may consent to all necessary treatment or testing for my child. This consent by proxy remains in effect until I rescind it on writing at some future date.

Name of Representative: ____

Relationship to Child: ____

This consent is only valid for this date of service.   Date of Service: ______________________

Parent (or Guardian) Signature: ____

Address: ____

City: ___________________________________   State: _________________________

Phone #: _________________________ Home

_________________________ Cell

_________________________ Work