

**Central Montana Medical Center  
Lewistown, MT**

***Authorization to Consent to Treatment***

---

I, the Guardian/DPOA of \_\_\_\_\_, do hereby authorize the Superintendent, Montana Mental Health Nursing Care Center, or Designee, as agent (s) for the undersigned to consent to any X-ray examination, laboratory, examination, medical or surgical diagnosis or treatment (minor surgical procedure not requiring informed consent and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any physician and surgeon who is licensed to practice in the State of Montana, whether such diagnosis or treatment is rendered at the Montana Mental Health Nursing Care Center or at the Central Montana Medical Center.

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 physician in the exercise of his best judgment may deem advisable.

This authorization shall remain ***effective for one year*** unless revoked in writing and delivered to said agent(s).

\_\_\_\_\_  
Guardian/DPOA

Witnesses:

\_\_\_\_\_

Date: \_\_\_\_\_

---

Authorization to Consent to  
Treatment of Patient

Addressograph