AUTHORIZATION TO TREAT A MINOR

I, ____________________________________________________________,
(Parent or guardian complete name)

Legal parent or guardian of ________________________________________,
(Patient complete name)

Give my permission to the following person, to seek medical treatment for my child.

_____________________________________        Date ______________________
(Parent/ guardian signature)

_____________________________________       Date _______________________
(Surrogate signature)

This authorization shall remain in effect until I cancel this permission in written form.

780 Canton Road. Marietta, GA 30060
4310 Johns Creek Parkway, Suite 180. Suwanee, GA 30024.
Phone: 404/943-0289. Fax: 404/943-978  www.childrescv.com