AUTHORIZATION TO TREAT MINOR

I, _____,
(print first, middle, last name)

Legal parent or guardian of _____,
(print first, middle, last name of minor child)

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

_____
(print first, middle, last name of surrogate)

I certify surrogate named above seeking medical attention for my child is an adult, over the age of eighteen (18).

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

_____ **Date**_____
Parent/guardian signature

_____ **Date**_____
Surrogate signature

Marietta:
777 Franklin Gateway, Marietta, GA 30067 Phone: 770.732.6007 Fax: 770.732.8242