3525 SUGARLOAF PARKWAY
LAWRENCEVILLE, GA 30044
PH- 678-377-1113 FAX- 678-377-9390

Permission to Treat Minor without a Parent/Guardian Present

This form gives us legal permission to treat your child in case you cannot accompany him/her to the clinic for treatment. Consent may include, but is not limited to clinic visits, medical treatment, immunizations, and tests.

Today's Date: ______/______/______

Patient Name:____

Date of Birth: ______/______/______

Parent/Guardian's Name:____

"I hereby authorize ____ to act on my behalf as an agent to give consent to any medical treatment by the physicians at Sugarloaf Pediatrics. I acknowledge that it is my responsibility to supply all necessary forms and information pertaining to the visit. I am responsible for all reasonable charges in connection with care and treatment."

In case of emergency, I can be reached at:

Primary Phone:______________________ Secondary Phone:__________________________

<u>This authorization shall remain effective until revocation in writing by the undersigned.</u>

____ Date: ______/______/______
Signature of Parent/Guardian

____ Date: ______/______/______
Witness