Gwinnett Pediatric Partners

MEDICAL TREATMENT AUTHORIZATION AND CONSENT FORM

The following form is designed for those situations where minors are unaccompanied by either parents or legal guardians. This gives authority to a designated adult to arrange for medical care which cannot be provided to a minor without approval by the parent(s) or legal guardian(s) unless there is written consent authorizing an agent to give approval.

Minor's Full Name: _____

Minor's Date of Birth: _____

Minor's Address: _____

_____

I authorize _____ (name of patient) to be evaluated by the provider on staff at Gwinnett Pediatric Partners. Authorization is hereby granted for all treatments and procedures. Unless revoked in writing, my signature below will act as authorization for today's and ALL future medical treatment.

The following individual(s) are authorized to be involved in my child's medical treatment including bringing him/her in for office visits and to make any necessary medical decisions:

Name_____ Relationship _____

Name_____ Relationship _____

Name_____ Relationship _____

Parent/Guardian: _____

Printed Name: _____

Address: _____

_____

Telephone #: _____

Date of Authorization: _____