

Cobb Pediatric Associates, PC

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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.***

Parent/guardian signature Date _____

Surrogate signature Date _____



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