Cobb Pediatric Associates

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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.

_____ Date_____

Parent/guardian signature

_____ Date_____

Surrogate signature