Authorization to Treat a Minor Patient

In the event that a parent or legal guardian is unable to accompany the child to an appointment, you may use this form to give another adult permission to bring your child to their visit(s). If this is to give a step-parent permission, both parents (with legal custody) need to sign and provide authorization.

I/We _____ and _____, the parent(s) and legal
(name of parent/guardian) (name of parent/guardian)

guardian(s) of _____, hereby authorize _____ to
(name of child) (name of adult accompanying child to office)

accompany my/our above named child to office visits with PANDA Neurology & Atlanta Headache Specialists and to consent to the examination and/or treatment of my child during the visit.

This authorization:

- ☐ Is effective only on _____
- ☐ Is effective from _____ to _____
- ☐ Is effective until revoked by me/us in writing.

I/We reserve the right to revoke this authorization at any time by writing to PANDA Neurology & Atlanta Headache Specialists at 5887 Glenridge Drive, Suite 140, Atlanta, GA 30328.

I understand that my child (under 18 years of age) cannot attend his/her appointment without the accompaniment of an authorized adult.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Parent/Guardian Date

Sworn to and subscribed before me this
_____ day of _____, 20 ___.

_____
NOTARY PUBLIC

My commission expires: