

CHILDREN'S HEALTHCARE OF ATLANTA (Children's)
AUTHORIZATION FOR CONSENT TO MEDICAL TREATMENT OF MINOR

In my absence, I, _____, who has the legal custody of my child,
(Parent/Legal Guardian)
_____ and whose birth date is _____,
(Child's name) (mm/dd/yyyy),
authorize _____ to provide consent to Children's Hospital(s) and/or
(Consenting adult)
Outpatient center(s) to render care under the supervision and advice of a licensed physician or
other medical care professional.

Please initial below the items you wish to allow the above individual to consent:

- _____ Medical exams and treatments
- _____ Dental exams and treatments
- _____ Surgical exams and treatments
- _____ Diagnostic imaging procedures
- _____ Laboratory tests
- _____ Anesthetic and/or sedation procedures

By signing this form, I am agreeing for the above individual to provide consent for my child from
_____ to _____. This consent may be removed at anytime
(mm/dd/yyyy) (mm/dd/yyyy)
by the parent/legal guardian, if requested in writing.

(Parent/Legal Guardian Signature)

(Date)

Special Note: For this authorization to be valid, the notary public certification below is required.

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

Date _____ (Affix seal here)

State of _____ County of _____

On this date, _____ personally appeared before me _____.
(Signer) (Notary)

Please initial one of the following:

_____ Personally known to me **OR**

_____ Proved to me on this basis of satisfactory evidence to be the person(s) whose name(s) is/are
subscribed and acknowledged to me that he/she/they executed the Authorization for Consent to Medical
Treatment of Minor.