4800 Olde Towne Parkway
Suite 430
Marietta, GA 30068
Phone: 770-321-1001
Fax: 770-321-8290

# NORTHSIDE HOSPITAL

**Northside East Cobb Orthopaedics & Sports Medicine**

Patient Name _____

Date of Birth ____/____/____
Month Day Year

I am the parent or legal guardian of the minor child/children identified below:

| Name | Date of Birth |
|---|---|
| | |
| | |
| | |
| | |
| | |

In case of my absence or unavailability, I authorize the following individuals to consent to medical treatment of the child/children named above at the Northside Hospital Affiliated Medical Practice (the "Practice"):

| Name of authorized representative | Relationship |
|---|---|
| | |
| | |
| | |
| | |
| | |

I agree that I will be financially responsible for and guarantee payment of any and all charges incurred in connection with the rendering of care to my child with the consent of one of the above named individuals.

I understand that health care providers at the Practice may disclose to the authorized individual appropriate information about my child's treatment or condition, such as discharge instructions and information about medication prescribed during that visit.

This authorization will remain in effect until I notify the Practice in writing that I wish to revoke or replace the form.

_____ _____

Signature of parent/legal guardian

Witness Date/ time
[Two witnesses required if verbal/telephone consent]

_____ _____

Date Time

Witness Date/ time

_____

Interpreter
(Note: if phone interpretation used, record interpreter ID#)

Reorder #28230 PP0080 (NECOSM_A)
Piedmont Graphics 07/20/16

**AUTHORIZATION TO TREAT MINOR**