Consent to Treatment of a Minor

I, being the parent or guardian of the following patient(s):

Patient Name	Date of Birth

do hereby request and authorize **Peachtree Park Pediatrics, LLP physicians and staff** to perform necessary services for my child(ren) which are deemed advisable by a physician, whether or not I am present at the actual appointment.

Below is a list of individuals (age 18 years or older) who have my permission to bring my child(ren) in for treatment, and/or make/cancel an appointment on their behalf:

☐ Patient(s) by him/herself if age 16 years or older (guardian must be reachable by phone during time of appointment)

Name	Relationship to Patient	Contact Phone Number

_____ _____

Signature of Parent or Guardian **Date**

_____

Printed Name of Parent or Guardian

3193 Howell Mill Rd NW, Ste 250 ● Atlanta, GA 30327-2100 ● T: (404) 351-1131 ● F: (404) 351-3515
Robert Wiskind, M.D. ● Nicole Ellerine, M.D. ● Anna Kuo, M.D. ● Shea Fleming, M.D.
Lauren Brown, M.D. ● Brian Winn, M.D. ● Brent Speer, M.D.