Northside Pediatrics
The best care for your kids

Authorization for Child to Receive Care

Dr. Allison B. Hill
Dr. Amy J. Hardin
Dr. Natalie M. Metzig
Dr. Tiji M. Philip
Dr. Adele H. Goodloe
Dr. Reshmi Basu
Dr. Katherine H. McGlamry
Dr. Brandon M. Estroff
Dr. Mary S. Thompson
Sara D. Dorsey, MSN, CPNP
Kathryn R. Hart, MSN, CPNP
Meredith M. Gillig, MSN, CPNP
Dr. Michael K. Levine, Emeritus
Dr. Ruth C. Brown, Emeritus
Dr. Jonathan D. Winner, Emeritus

I hereby authorize Northside Pediatrics and Adolescent Medicine, PC to examine and treat my minor child, _____,

birthdate: _____, **when he/she is accompanied by**

_____,

relationship to patient:_____ .

I understand that I may revoke this consent at any time.

_____ _____

Parent/Legal Guardian Date

----------**OR**----------

I hereby authorize Northside Pediatrics and Adolescent Medicine, PC to examine and treat my minor child, _____,
birthdate: _____, **when he/she is unaccompanied by an adult**.

I understand I may revoke this consent at any time.

_____ _____

Parent/Legal Guardian Date

Sandy Springs
6095 Barfield Road
Suite 200
Sandy Springs, GA 30328
Tel: 404-256-2688
Fax: 770-685-7114

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250 Parkbrooke Place
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