Consent to Treat In Parental/Guardian Absence

My name is ___________________________________ and I am the legal parent and/or guardian of ___________________________________, date of birth ___________, a minor under the care of Conyers Pediatrics.

In the event I an unable to accompany the above named patient to Conyers Pediatrics, I authorize the following person(s) to serve as my representative(s) and bring my child to the office for treatment (including medical tests and/or immunizations as recommended by the treating physician). I authorize Conyers Pediatrics, its physicians and staff, to provide medical information to the following person(s) pertinent to my child's immediate care as if I were personally present. I understand that each person designated will be required to provide a photo ID as proof of identity and I have advised them of same.

This authorization is valid for one year from the date of signature and must be updated annually.

_____________________________ _________________________
Name Relationship

_____________________________ _________________________
Name Relationship

_____________________________ _________________________
Name Relationship

_____________________________ _________________________
Parent or Guardian Signature Date

_____________________________ _________________________
Witness Date

To be completed by Conyers Pediatrics

The parent or guardian of ______________________________ is not present. By signing below, we verify that this form has been read to _____________________________________, the parent or guardian, and verbal permission has been granted over the telephone for treatment as determined by the physician, including but not limited to laboratory tests, xrays, injections, immunizations, etc.

This the ___ day of ____________________.

_____________________________ _________________________
Employee Name Title

_____________________________ _________________________
Employee Name Title

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