

**ATLANTA WOMEN'S HEALTH GROUP, P.C. ("AWHG")**  
**CONSENT FOR TREATMENT OF A MINOR BY PARENT/LEGAL GUARDIAN**

According to Georgia law, a parent or legal guardian must consent to the treatment of a minor (any person under 18 years of age) except under certain circumstances.

I, the undersigned, as the parent or legal guardian of \_\_\_\_\_, DOB: \_\_\_\_\_ (the "minor") have the legal authority to give consent for the treatment of this minor. I hereby authorize such diagnostic, medical and/or surgical treatment of such minor as may be considered necessary or appropriate under the circumstances for the treatment of any medical condition except as specifically described below. I agree that treatment may be provided in my absence. This consent shall remain in effect unless revoked in writing.

Identify any limitations on the kinds of medical services for which this authorization is given. If none, state "none".

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In addition, I have the legal right to delegate such consent to a proxy decision maker (the "proxy"), who is an adult and legally and mentally competent to exercise the authority so delegated. If the nature of the medical care is not routine, please try to contact me regarding the health care of my child at the following telephone number. If you are unable for any reason to contact me, you may rely on the proxy for consent. Be advised that protected patient health information may be shared with the proxy to facilitate informed decision making.

Parent/Legal Guardian Name: \_\_\_\_\_ Relationship to Minor: \_\_\_\_\_  
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Proxy Name: \_\_\_\_\_ Proxy Contact #: \_\_\_\_\_  
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Signature of Parent or Legal Guardian                      Date                      Parent/Legal Guardian  
Contact #