The Family Health Centers of Georgia, Inc.

AUTHORIZATION TO TREAT
IN ABSENCE OF PARENT/LEGAL GUARDIAN

I, _____, hereby authorize _____,
(parent/legal guardian) (specify authorized representative's name)

_____ to bring my child, _____,
(specify authorized representative's relationship to child) (specify child's name)

to The Family Health Centers of Georgia, Inc. or its affiliates to be receive medical care.

I further give permission for the above mentioned individual to access _____'s
(specify child's name)
confidential health information for care and treatment.

I further verify that I have received a copy of the Notice of Privacy Practices for Protected Health Information that explains my rights regarding protecting my child's confidential health information and that this notice will be valid for a period of one year from the date it was issued.

XSignature of Parent/Legal Guardian:_____

Date Signed:_____

Witnessed by:_____ Date:_____
(FHCGA authorized representative)

OR

Witnessed by:_____ Date:_____
(Notary Public)

my commission expiration date:_____/_____/_____

Please return completed form to the location indicated below.

For internal use only

Location name: _____

Fax #: _____

Email address: _____

Attn: _____

Notary Seal