THE WORLD OF PEDIATRICS

Dr. Lyudmila Vayman
3005 Royal Blvd S., STE 100 Alpharetta, GA 30022
Tel: 770-442-5437 Fax: 770-674-3777

Authorization for Treatment of a Minor without the Parent or Legal Guardian Present

Patient's Name: ______________________________ Patient's Date of Birth: _____________

To whom it may concern:

I, ____, the legal guardian or parent of ____, give authorization for the individuals listed below to make medical decisions in my absence for the health and well-being of the child listed above. These individuals may authorize and sign for all medical procedures and/or treatments performed in Dr. Lyudmila Vayman's office. This authorization extends to urgent care centers, hospitals or other medical specialists and medical offices that may be needed to treat my child in my absence. I will be responsible for all financial obligations incurred for procedures performed.

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This authorization will remain in effect indefinitely from the date listed above until receipt of written withdrawal of this authorization.

Regards,

______________________________	______________________________
Signature	Date
______________________________	______________________________
printed name	relationship to the patient