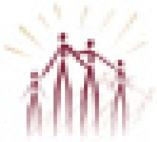

SOUTH FORSYTH FAMILY MEDICINE AND PEDIATRICS
1845 Lockeway Drive, Suite 404
Alpharetta, Georgia 30004
Phone: 770.343.9112
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David S. Boaz, M.D.~Mark Glodener, M.D.~Giouzel Glodener, M.D.

MEDICAL CARE AUTHORIZATION FORM

I, ______________________________, mother/father/guardian to ________________________,
(Name of Parent/Guardian) (Child's Name)

give authorization for ______________________________, _____________________ to bring
(Name of Person) (Relationship)

my child for doctors appointment on my behalf. I authorize this person to sign for medical treatment on my behalf, this is including vaccinations, etc. If there are any questions or concerns, the doctor can reach me, during my child's visit, on the numbes given below.

This authorization can be negated at any time by either party. I understand South Forsyth Family Medicine will give my proxy all information pertinent to my child's health during these appointments.

____ ______________________________
(Parent/Guardian Signature) Witness

____ ______________________________
(Contact Telephone Number) (Date)