Authorization for Treatment

The undersigned has been informed of the treatment considered necessary for the patient whose name appears below and that the treatment and procedures will be performed by physicians and employees of Kids First Pediatrics of Georgia. Authorization is hereby granted for such treatment and procedures and the administration of anesthetics, medications, or other therapies that may be deemed necessary. I consent for myself or on behalf of the patient that selection and assignments on a physician and agree to make arrangements with him/her for obtaining a complete diagnosis and continuation of treatment as needed. I certify that I have read the above authorization and understand I; I also certify no guarantee or assurance had been made to me as to the result that may be obtained by this treatment.

Patient's Name_____ DOB_____

Signature of Patient/Guardian _____

Relationship to Patient _____

Date signed _____