Rockdale Pediatrics Healthcare P.C.
2020 Honey Creek Pkwy S.E. Suite E
Conyers, Ga. 30013
Ph (770)922-0553 • Fax (770)922-6882

Date: ___/___/______

Mother/father/legal guardian (circle one) ________________________________
(name)

I have sole/joint (circle one) custody of __________________________________
(patient's name)

I authorize/consent the following people over the age of 18 to bring the patient named above to Rockdale Pediatrics Healthcare, Dr. Jarwar's office if I am not able to myself.
Please note that biological parent or legal parent must be present at first visit for the duration of the visit.

____
(Parent/Legal Guardian signature)

Permission being granted to the patient's:

- ☐ Grandmother _________________________________
  (Name)
- ☐ Grandfather _________________________________
  (Name)
- ☐ Aunt _________________________________
  (Name)
- ☐ Uncle _________________________________
  (Name)
- ☐ Family Friend _________________________________
  (Name)
- ☐ Sibling _________________________________
  (Name)
- ☐ Step-parent _________________________________
  (Name)
- ☐ Other _________________________________
  (Name & relation to patient)

---I.D. WILL BE REQUIRED ***EVERYTIME*** SOMEONE AUTHORIZED BRINGS CHILD---

Good from date signed to 12 months after unless revoked earlier