AOG

Atlanta Obstetrics & Gynecology Associates
275 Collier Road, NW, Suite 100-C
Atlanta, Georgia 30309
Telephone 404.355.0320 Fax 404.351.0909

Consent to Diagnose and Treat
A Minor Child

I, _____ would like my minor child,
_____, Date of Birth _____
To become a patient of Atlanta Obstetrics & Gynecology Associates, a Division of Atlanta Women's Healthcare Specialists, LLC.

_____ I hereby consent that she be diagnosed, treated, and receive preventive care for all Gynecological and obstetrical conditions, including birth control, sexually transmitted Diseases, and pregnancy.

_____ I understand that the doctors feel strongly about the privacy of the patient-physician relationship. The patient will be asked to give her permission before anyone at Atlanta Obstetrics & Gynecology Associates will discuss her care with another person.

_____ _____
Signature of Parent or Legal Guardian Date

_____ _____
Signature of Witness Date