Albemarle Counseling Group
1129 Horseshoe Road
Elizabeth City, NC 27909

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MEDICAL POWER OF ATTORNEY OVER A MINOR CHILD

State of North Carolina)
County of Pasquotank)

I, _____ *of*
(Name)

_____
(Address)

do solemnly swear that:

1. *I am the legal guardian of:*

Name of Child	*Child's Date of Birth*	*Relationship: (Please initial in appropriate space)*	
		Biological Parent & Legal Guardian	*Legal Guardian*

2. *I authorize* _____
(Name of Person/)

of _____
(Address)

to assume limited medical power of attorney over my minor child. I appoint above named person as my true and lawful attorney for the purpose of performing the medical duties checked below. My signature on this document gives authorization for the designated person to perform the following responsibilities for the above specified child:

LEGAL GUARDIAN—PLEASE INITIAL ALL APPLICABLE RESPONSIBILITIES

_____ *Initial* — *To bring the child to Albemarle Counseling Group for psychological testing, assessment, treatment, and/or psychotherapy.*

_____ *Initial* — *To participate in the child's psychotherapy at Albemarle Counseling Group.*

_____ *Initial* — *To receive copies of written reports concerning the above named child from Albemarle Counseling Group.*

_____ *Initial* — *To receive copies of the following specific report(s) from Albemarle Counseling Group: {Please specify which report(s)}.*

3. *This Power of Attorney will begin on:* _____ *and expire on* _____.
Date *Date*

(The Power of Attorney will automatically expire automatically in one year unless I revoke it earlier.)

4. *I have given this consent of my own free will.*

_____ _____
Signature or parent or guardian giving power of attorney *Date*

_____ _____
Witness *Date*