PREAUTHORIZATION TO TREAT MINORS
CONSENT FORM

This form authorizes ENT and Allergy Associates, LLP to provide medical care or treatment to a minor who is accompanied to an office visit by an adult who is *not* the minor's parent or legal guardian, ex: a babysitter. The form also authorizes ENTA to provide such care to a sixteen or seventeen year old child without an accompanying adult. Please review the authorization and complete if you wish to authorize such treatment.

AUTHORIZATION

I appoint _____, who is
(Name) (Address)

my child's _____ as my proxy decision maker for consenting to
(Specify Nature of Relationship to Minor)

the delivery of medical care for my child, _____
(Name of Minor) (Minor's DOB)

in my absence.

LIMITATIONS

Identify any limitations on the kinds of medical services for which this authorization is given. If none, state "None."

_____

_____

Identify any limitations on the time frame for which this authorization is given. If none, state "None."

_____

_____

I understand that this consent may be revoked at any time in writing to ENT and Allergy Associates, LLP.

CONTACT INFORMATION

If the nature of the medical care is not routine or considered urgent, please contact me (us) regarding the healthcare of my child at the following phone numbers:

Parent/Guardian Name: _____

Mobile Phone Number: _____

Daytime Phone Number: _____

Parent/Guardian Name: _____

Mobile Phone Number:_____

Daytime Phone Number: _____

Signature(s) of parent(s) or legal guardian(s):

_____ /_____
Please print full name ***Relationship***

_____/_____
Signature ***Date***

_____/ _____
Please print full name ***Relationship***

_____/_____
Signature ***Date***

FOR MINORS SIXTEEN (16) or SEVENTEEN (17) YEARS OF AGE

I give my permission for "routine" treatment (ex: allergy shots) to be administered without my presence, or the presence of another accompanying adult as deemed necessary by the physician.

_____ (Parent /Guardian Initial)