



# 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 ENT 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: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Mobile Phone Number: \_\_\_\_\_

Mobile Phone Number: \_\_\_\_\_

Daytime Phone Number: \_\_\_\_\_

Daytime Phone Number: \_\_\_\_\_

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

\_\_\_\_\_ / \_\_\_\_\_

*Please print full name*

*Relationship*

\_\_\_\_\_ / \_\_\_\_\_

*Please print full name*

*Relationship*

\_\_\_\_\_ / \_\_\_\_\_

*Signature*

*Date*

\_\_\_\_\_ / \_\_\_\_\_

*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)