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 my child’s ____________________________________________, as my proxy decision maker for consenting to the delivery of medical care for my child, ____________________________________________, 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: ___________________________

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)