Pediatric Ear, Nose & Throat Specialists

AUTHORIZATION TO BRING PATIENT TO OFFICE VISIT AND/OR FOR TREATMENT AND COPIES OF RECORDS

Patient Name: _____ DOB: _____

I, _____ hereby authorize the following individual(s) to (1) accompany my child, (2) make healthcare decisions and (3) receive copies of his/her medical records in my absence. I give consent to all medical treatment to be rendered. **I understand that this authorization does NOT apply to bringing my child for surgery. I must accompany my child to surgery.**

Name: _____ Relation to patient: _____

Name: _____ Relation to patient: _____

Name: _____ Relation to patient: _____

This authorization also grants to my agent(s) the power to sign for release of information to any third party payers who may be responsible for part or all of the cost of the services provided. This authorization shall remain effective from _____ to _____, unless sooner revoked in writing.

_____ _____

Signature of Parent/Legal Guardian Date Signed

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