ENT MEDICAL SERVICES, PC
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Authorization for Medical Treatment of Minor Child

This form, "Authorization for Medical Treatment of a Minor Child" is completed by a parent or court appointed legal guardian who is unavailable at the time of their child's appointment and wants to grant authority to another person to obtain medical treatment for their child.

Please send any pertinent health information with the authorized individual to the patient's appointment. This includes any and all (1) allergies, (2) current medications and (3) past medical/surgical history.

I hereby authorize _____ at phone #_____ to give consent for all medical and/or surgical treatment that may be required for my child during my absence.

Child's Full Name:_____ Date of birth:_____

Parent/guardian Address:_____

Parent/guardian Telephone
(Home):_____ (Cell):_____ (Work):_____

Primary Medical Insurance Information
Plan Name:_____
Subscriber:_____
Subscriber DOB:_____
ID #:_____
Group #:_____

Secondary Medical Insurance Information
Plan Name:_____
Subscriber:_____
Subscriber DOB:_____
ID #:_____
Group #:_____

_____ _____
Signature of Parent / Court Appointed Guardian Date

_____
Printed Name of Parent / Court Appointed Guardian

_____ _____
Signature of ENT Office Staff Witness Date

_____
Printed Name of ENT Office Staff Witness

If form is not signed at ENT Medical Services in front of a witness, the signature of the parent or court appointed legal guardian needs to be notarized.

Notary Acknowledgement

State of _____

_____ County,

On this ____day of _____, 20___, before me appeared

_____, as the Parent/Court Appointed Guardian who proved to me through government issued photo identification to be the above-named person, in my presence executed *"Authorization for Medical Treatment of Minor Child"* and acknowledged that he/she executed the same with his/her free act and deed.

_____
Notary Public

Print Name: _____

My commission expires: ____/____/____