Telephone/Office Consent to Treat a Minor

I give my consent to Ear, Nose & Throat *Specialty Care* and to Dr. _____. To perform minor office procedures on _____, Date of Birth _____/_____/_____.

(Name of patient)

I also give permission to: _____, Relationship to Patient: _____, to make medical decision in my absence.

I acknowledge that I will be responsible for any bills incurred for the treatment of this minor.

This authorization will expire 6 months from the date signed, unless an earlier date is provided here: _____.

Parent/guardian printed name: _____

Parent/guardian signature & date: _____

Staff name: _____ Witness name: _____