ENT & Allergy Specialists

Authorization to Treat Patient Under the Age of 18

Please Print

I, _____, authorize ENT & Allergy Specialists to provide medical treatment to my child, _____ __/___/_____in my absence.
(Child's First, Middle, Last Name and DOB)

This authorization expires on _____.
(Month and Year)

People listed below are authorized to bring my child for their appointments and authorized to make medical decisions in my absence:

_____
(Name and relationship to patient)

_____
(Name and relationship to patient)

_____
(Name and relationship to patient)

Signature of Parent or Legal Guardian of underage patient:

_____
Date: _____
Relationship to Minor: _____