Adult and Pediatric Ear, Nose & Throat

Consent to Examine and Treat a Minor

I, ________________________________, do hereby consent and authorize Adult & Pediatric ENT physicians, and/or such assistants or designees, to examine and treat my_________________________, _______________________________________.
(Relationship) (Patient's name)

1. I affirm that I have the legal right to consent to this.
2. This consent is binding until specifically revoked by myself or another person who has the right to sign or revoke this form.
3. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of examination of treatment.

Authorization to Treat a Minor Patient in Absence of Parent/Guardian

In the event of my absence, I do hereby authorize ________________________
(Name of person(s)
to accompany my child to office visits for non-emergent examinations and/or treatment as deemed necessary by Adult & Pediatric ENT physicians.

This authorization is effective until revoked by me in writing.

__________________________________ ___________________
Printed Name of Legal Guardian **Date**

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Signature of Legal Guardian

Return fax #: 1-855-233-7157