ear, nose & throat associates OF CORPUS CHRISTI

DISEASES and SURGERY of the EAR, NOSE & THROAT and FACIAL PLASTIC and RECONSTRUCTIVE SURGERY

PARENTAL PREAUTHORIZATION for MINORS

For families who have established relationships with our practice, it may be convenient to have on file prior authorization for medical care for children when a parent cannot be present for treatment. This form authorizes EAR, NOSE, AND THROAT ASSOCIATES to provide medical care or treatment to a minor who is accompanied to an office visit by an adult who is *not* the minor's parent or legal guardian.

AUTHORIZATION

I appoint _____ who is,
(Name) (Address)

my child's _____ as my proxy decision maker
(Specify Nature of Relationship to Minor)

for consenting to the delivery of medical care for my child, _____
(Name of Minor) (Minor's DOB)

in my absence.

LIMITATIONS

Identify any limitations on the kinds of medical services for which this authorization is given. If none, state "NONE".

_____

_____

Identify any limitations on the time frame for which this authorization is given. If none, state "NONE".

_____

_____

I understand that this consent may be revoked at any time in writing to EAR, NOSE, AND THROAT ASSOCIATES.

CONTACT INFORMATION

If the nature of the medical care is not routine or considered urgent, please contact me (us) regarding the healthcare of my child at the following phone numbers:

Parent/Guardian Name _____

Mobile Phone Number: _____

Daytime Phone Number: _____

Parent/Guardian Name: _____

Mobile Phone Number: _____

Daytime Phone Number: _____

Signature(s) of parent(s) or legal guardian(s):

_____/_____
Please print full name ***Relationship***

_____/_____
Signature ***Date***

_____/_____
Please print full name ***Relationship***

_____/_____
Signature ***Date***

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