MIDWEST
EAR, NOSE & THROAT SPECIALISTS

Consent to Provide Treatment for a Minor Child

This form allows someone other than a parent or legal guardian to make medical decisions as if they were the parent. Be advised that protected patient health information (PHI) may be shared with the proxy to whom the right to consent has been delegated to facilitate informed decision making.

Child's name:_____ **DOB:** _____

I give consent by proxy for medical decisions to (list each proxy, use additional forms if more than 2 individuals):

Name: _____ **Name:** _____

Phone: _____ **Phone:** _____

Relationship to the child:_____ **Relationship to the child:**_____

This consent applies to any necessary examination, medical diagnosis, treatment and/or care to be rendered to the above named minor child under general or special supervision based on the advice of any health care professional. I (we) agree to pay for all services provided to my child in my absence.

Limitations

Identify any limitations on the types of medical services for which this authorization is given. If none, please check the corresponding box.

□ **No limitations**

Limitations:_____
_____
_____

This consent is valid until revoked by the parent or legal guardian. If a specific time frame applies to this authorization, please note time frame below.

Time frame for which this authorization is given: _____ TO _____

Parent Contact Information

If the medical care is not routine, please try to contact me regarding the healthcare of my child at the following telephone numbers. If you are unable to contact me, please rely on this proxy decision maker for consent.

Parent Name_____ Parent Name_____

Cell Phone:_____ Cell Phone:_____

Day Phone _____ Day Phone _____

Evening Phone:_____ Evening Phone:_____

Signature:_____ **Date:**_____