ENT Associates, Inc.

A division of SOUNDHEALTH SERVICES

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR PATIENT

Under Missouri law, prior to providing medical treatment to a patient under the age of eighteen years old in a non-emergency situation, ENT Associates, Inc. must obtain consent from the minor's parent or legal guardian prior to treating the patient. If there is likely to be an occasion where your child will be brought to our office for treatment by an adult relative, babysitter, or other person over the age of eighteen years of age, as the parent or legal guardian, must first delegate such person with the authority to consent to your minor child's treatment on your behalf.

I,______________________________ , of ______________________________________
(Name) (Address)

the parent or legal guardian of:

Name of Patient: __________________________________ Date of Birth: ________________

hereby delegate and authorize the following adult individuals, in my absence, to consent to the care of my minor child and to sign any necessary waivers on my behalf.

Name	Relationship to Patient
___________________________________	___________________________________
___________________________________	___________________________________
___________________________________	___________________________________

During such periods of time such designated adults shall also have the authority to access and to consent to the use and disclosure of the minor child's protected health information.

THE UNDERSIGNED ACKNOWLEDGES AND AGREES TO PAY ALL COSTS AND EXPENSES INCURRED IN CONNECTION WITH ANY MEDICAL TREATMENT RENDERED BY ENT ASSOCIATES TO THE MINOR PATIENT FOLLOWING THE CONSENT OF ONE OF THE ADULTS DELEGATED ABOVE.

____ _________________________
Parent/Legal Guardian Signature Date

____
Parent/Legal Guardian Name

THIS AUTHORIZATION WILL BE IN EFFECT UNTIL CHANGED OR REVOKED BY THE ABOVE PARENT OR LEGAL GUARDIAN.

Please complete the patient information section on the following page regarding your minor child's health information

Treatment of Minor 10-1-2012

MINOR PATIENT HEALTH AND PAYMENT INFORMATION

FOR RETURNING PATIENTS ONLY

As a parent or legal guardian delegating the authority to consent to the treatment of your minor child in your absence, it is your responsibility to ensure that the following information provided on this form is accurate, complete, and up to date.

Complete this information if any changes are applicable:

MEDICAL INSURANCE INFORMATION:

Company:________________ Claims Address:_________________________
Policy #: ________________ Group # __________________________
Subscriber: _______________ Subscriber DOB:______________
Subscriber address: ____________________________________

CHILD'S MEDICAL HISTORY:

Allergies:
____

Chronic Conditions:
____

Dietary or Other Restrictions:

____

Medications that your child takes on a regular basis:

Medication Name	Dosage	Frequency
_______________	_______________	_______________
_______________	_______________	_______________
_______________	_______________	_______________

I, _____________________, the parent or legal guardian of __________________, acknowledge and agree that it is my responsibility to ensure that the information contained in this form remains up to date and accurately reflects the health information of my child.

___________________________________ ______________________________
Parent/Legal Guardian Signature Date

____
Parent/Legal Guardian Name