HUNTERDON
OTOLARYNGOLOGY
& Allergy Associates

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PREAUTHORIZATION TO TREAT MINORS
CONSENT FORM

This form authorizes Hunterdon Otolaryngology & Allergy Associates to provide care for treatment to a minor who is accompanied to our office by an adult who is not the minor's parent or legal guardian, ex: other family member or babysitter. Please review the authorizations and complete if you wish to authorize such treatment.

AUTHORIZATION

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

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

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 ENT and Allergy Associates, LLP.

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: _____ Parent/Guardian Name: _____

Mobile Phone Number: _____ Mobile Phone Number: _____

Daytime Phone Number: _____ Daytime Phone Number: _____

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

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

_____ / _____ _____ / _____
Signature *Date* *Signature* *Date*