HUNTERDON OTOLARYNGOLOGY & Allergy Associates

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PREAUTHORIZATION TO TREAT MINORS

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 (e.g., another family member or a babysitter). Please review the authorizations and complete this form if you wish to authorize such treatment.

AUTHORIZATION

I appoint _____
Name Address

who is my child's _____ as my proxy decisionmaker for consenting to the

delivery of medical care for my child _____ in my absence.
Name of Minor Minor's DOB'

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 I may revoke this consent at any time in writing to Hunterdon Otolaryngology & Allergy Associates.

CONTACT INFO

If the nature of the medical care is not routine or considered urgent, please contact me (us) regarding the health care 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