Proliance South Seattle Otolaryngology

CONSENT FOR CARE OF MINOR BY NON-PARENT

The purpose of this Consent Form is to ensure efficient and timely execution of medical advice and treatment plans, the goal of which is to serve the best interest of the minor. Under certain circumstances consent may be given to other parties with the express written consent below.

AUTHORIZATION TO TREAT A MINOR

I, ___________________________, the parent/legal guardian, give my consent for the following people to seek medical care for the below listed child/children in the event I or another parent/legal guardian am unable to be present for appointment:

Name of Minor: __________________________________
Date of Birth: ____________________________________

Consent Granted To:
Name: ____
Relationship to Minor: _____________________________

I acknowledge that is order for PSSO – Proliance South Seattle Otolaryngology to administer vaccines/injections or other treatment to my child in my absence, I must give my permission. I am aware that I have the right to withdraw my consent for any reason and at any time upon written notice of this desire. I hereby state that I have read and understand this consent.

____
Signature of Parent or Legal Guardian

____
Date

PARENTAL/GUARDIAN VERBAL CONSENT

The parent/guardian/verbal consentor ________________ (name) of ____________________ (patient's name) were notified by phone and have given consent for the patient to be seen today ___________________ (date) for ____ (reason for visit).

____
Witness – Title

____
Date