PARENTAL PREAUTHORIZATION FOR MINORS

For families who have established relationships with our practice, it may be convenient to have on file prior authorization for medical care for children when a parent cannot be present for treatment. Please complete the following form if you want to authorize the treatment in advance.

I request and authorize Ear, Nose & Throat Associates and its personnel to deliver medical care to my child listed below:

Child Name _____ Date of Birth _____

Please try to contact us regarding the health care of our child at the following number(s):

Parent Name _____ Phone _____

Parent Name _____ Phone _____

Other _____ Phone _____

Note: If any special parental or custodial relationship exists (such as if the child has one parent only or if legal custody is held by guardians in the absence of both parents), please explain the situation below, along with your signature, printed name, and a contact phone number.

Parent or Guardian Name _____ Date _____

Parent or Guardian Signature _____ Date _____

Relationship to Patient _____