Carolina Ear, Nose & Throat
Head and Neck Surgery Center

AUTHORIZATION FOR CONSENT TO MEDICAL TREATMENT FOR MINOR

I, _____, as the parent/guardian of

_____,
(Full name of Minor)

do hereby empower and grant to:

_____

Name Address Phone Number

And/or

_____

Name Address Phone Number

the right to consent permission to any acts which may be necessary or proper to provide for the health care of the minor child, including but not limited to any X-ray , examination, anesthetic, medical or surgical diagnosis, treatment and/or Hospital Care, to be rendered to the minor under the general or special supervision and on the advice of any physician or surgeon licensed to practice in the state of North Carolina. This authorization shall be valid for the period of time commencing on _____ and ending on _____. I do hereby indemnify and hold harmless the physician, hospital, and other persons who act in reliance upon this authorization.

Executed this _____day of _____ 20____.

_____ _____

Witness Parent/Guardian

Contact Information:
Parent/Guardian can be immediately contacted at the following phone number(s):