Concord Otolaryngology
Head & Neck Surgery P.A.

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AUTHORIZATION TO CONSENT TO MEDICAL TREATMENT OF A MINOR CHILD

Patient				
Name	DOB	Address	Phone	Alt Phone

Parent/Legal Guardian				
Name	DOB	Address	Phone	Alt Phone

Appointed Proxy				
Name	DOB	Address	Phone	Alt Phone

I , ______________________ *(parent/legal guardian's name)*, acknowledge that I am the lawful parent/guardian of and that there are no court orders or other documents in effect that would prevent me from conferring the power of consent to another person.

I hereby authorize and appoint ________________________________ *(appointed proxy)* to consent to my child's medical examination and treatment. I give this consent voluntarily in order to make sure that my child receives adequate healthcare. This authorization will remain in effect for a period not exceeding one year.

Limitations: Identify any limitations on the kinds of medical services for which authorization is given. If none, state "none".

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Contact: If the nature of the medical care is not routine, please try to contact me. If you are unable to contact me for any reason, you may rely on the proxy decision maker for consent.

Signed and date this ___________*(date)*day of ______*(month)*, __________*(year).*

Parent Legal Guardian	**Witness**	**Witness**
Signature	Signature	Signature
Print Name	Printed Name	Printed Name