PENTA
Pediatric Ear, Nose & Throat of Atlanta, P.C.

Putting Your Child First

404.255.2033

AUTHORIZATION TO GIVE CONSENT TO LIMITED MEDICAL TREATMENT

I, Parent's Name _____ (First) _____ (Last) parent and/or legal guardian (hereafter referred to as PARENT) of Child's Name _____ (First) _____ (Last) (hereafter referred to as CHILD), grant permission and authority to Authorized Adult's Name _____ (First) _____ (Last) (hereafter referred to as AUTHORIZED ADULT), to consent for medical treatment of CHILD at Pediatric Ear, Nose & Throat of Atlanta, P.C. (hereafter referred to as PENTA). This consent shall be limited to care, treatment and procedures provided in the offices of PENTA and shall not apply to surgery or procedures provided outside the office.

This consent does not apply to new patient visits and pre operative visits. The PARENT must be present on these types of appointments.

PENTA reserves the right to revoke this agreement and require the PARENT to be present for any or all visits if the treating physician feels that it would be in the best interest of the child to have PARENT present.

This authorization shall not be valid for more than one year. If PARENT wishes to have the authorization terminate earlier

please indicate date: _____ – _____ – _____
Complete date

Patient Name _____ (First) _____ (Middle) _____ (Last)

Parent Name _____ (First) _____ (Last)

_____ _____ – _____ – _____
Parent signature Date

Authorized Adult Name _____ (First) _____ (Last)

_____ _____ – _____ – _____
Authorized Adult Signature Date

RESET FORM