AUTHORIZATION TO GIVE CONSENT TO LIMITED MEDICAL TREATMENT

PENTA
Pediatric ENT of Atlanta
Where Children Are First™

I, ________________ ________________ parent and/or legal guardian (hereafter referred to as PARENT) of
First Last

________________ ________________ (hereafter referred to as CHILD), grant permission and authority to
First Last

________________ ________________ (AUTHORIZED ADULT), to consent for medical treatment of CHILD at Pediatric
First Last

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: ______ ______ ______
Month Day Year

Patient Name: ________________ ________________ ________________
First Middle Last

Parent Name: ________________ ________________
First Last

____ _____/_____/_______
Parent Signature Date

AUTHORIZED ADULT Name: ________________ ________________
First Last

____ _____/_____/_______
Authorized Adult Signature Date