AUTHORIZATION TO TREAT MINOR PATIENT

Please list all friends and/or family that will be allowed to escort the minor child:

NAME DATE OF BIRTH RELATIONSHIP TO CHILD

_____

_____

_____

_____

_____

I, the parent/legal guardian of _____, date of birth_____, hereby authorize the friends and/or relatives listed above to escort my child to appointments and/or for treatment at Spokane Ear, Nose & Throat Clinic in my absence. I will supply my proxy with any and all information that may have changed including, but not limited to: insurance coverage, phone numbers and address information. They have been given my permission to represent the minor child.

_____

__ MOTHER __FATHER __LEGAL GUARDIAN __OTHER: _____

SIGNATURE_____DATE_____