Middle Tennessee Ear, Nose & Throat

Parental/Guardian Authorization for Treatment of Minors

I authorize the provision of medical or hospital care deemed necessary for:

Patient Name_____**SS#**_____

Last *First* *MI*

Address_____**City/St.**_____**Zip**_____

Street # *Street Name* *Unit/Apt#*

Date of Birth _____/_____/_____ **Age**_____ * **Male** / **Female** *

**The undersigned hereby authorizes and grants permission to:

1._____ 2._____

3._____ 4._____

to act in my place during my minor child's visit to Middle Tennessee Ear, Nose & Throat. This authorization is in effect commencing_____ and ending on_____.

** The undersigned hereby authorizes and grants permission to:

1._____ 2._____

3._____ 4._____

to sign in my place during my minor child's visit to Middle Tennessee Ear, Nose & Throat, giving authorization to file my health insurance for my minor child's visit,

Insurance Co:_____Policy #:_____

Must provide picture ID and valid insurance card – front & back.

**I do hereby indemnify and hold harmless the physician, facility and other persons who act in reliance upon this authorization.

Executed this_____day of _____ 20_____.

X_____ **Date**_____

Signature of Parent or Guardian

X_____ **Date**_____

Signature of Witness

INFORMATION:

Parent/Guardian can be located at the following address/phone number: _____

Address

_____ _____ _____

Home Phone Work Phone Cell Phone