ENT & ALLERGY
ASSOCIATES P.S.

MEDICAL AUTHORIZATION FOR MINORS

I,_____, the parent or legal guardian of

_____, a minor, do hereby authorize and one or more of

_____, _____ or

_____, as agents for myself in my absence or incapacitation to consent to any x-ray examination and anesthetic, medical or surgical diagnosis or treatment and medical care which is deemed advisable by and is to be rendered under the general or special supervision of any physician or surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any hospital whether or not such diagnosis or treatment is rendered at the office of said physician or said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of the aforesaid agents to give specific consent to any and all such diagnosis, treatment or hospital care which aforementioned physician in the exercise of his or her judgement may deem advisable.

I hereby authorize any hospital which has provided treatment to the above named minor to surrender physical custody of such minor to the above named agents upon completion of treatment.

These authorizations shall remain effective until _____.

Signature of Parent or Legal Guardian _____ Date _____

Please note any special health plan or insurance information such as membership or policy numbers on the back of this form.

Copies of this form, duly executed, should be in the possession of the named minor, at least one adult named in the document and present at the event and the parent or guardian executing the Medical Authorization.

STATE OF _____

COUNTY OF _____

SUBSCRIBED AND SWORN TO before me this _____ day of _____ ,20_____

_____ (notary seal)

Notary Public

My Commission Expires _____

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