CONSENT TO TREAT

Parent/Guardian Name: _____ Phone Number: _____

I am the: ☐ Parent
☐ Guardian
☐ Other person having legal custody _____
Describe the legal relationship

of _____ , a minor. I hereby authorize _____
Name of the legal agent

to act as my agent to consent to any examination, anesthetic, medical, surgical or diagnostic treatment, and hospital care that is recommended by, and to be rendered under the general or special supervision of, any licensed doctor or provider at Western Michigan ENT, PC, whether such diagnosis or treatment is rendered at the doctor's office or at a hospital.

I understand that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but it is given to provide authority to the above-named agent to give consent to all such diagnosis, treatment or hospital care that a licensed doctor or provider at Western Michigan ENT, PC recommends/provides.

These authorizations shall remain in effect until _____ unless sooner revoked in writing.
(month, day and year)

Signature: _____ Date: _____ Time: _____
(Parent, guardian or other person above having legal custody)

Print Name: _____ Date: _____ Time: _____
(Parent, guardian or other person above having legal custody)

Witness Signature: _____ Date: _____ Time: _____

Print Witness Name: _____ Phone Number: _____

****Inner Office Use****

_____ Copy given to agent _____ Copy scanned

updated 5-22-24