Eastern Oklahoma
Ear, Nose & Throat, Inc.

AUTHORIZATION FOR INFORMATION AND MEDICAL CARE FOR PATIENTS 17 YEARS AND UNDER

Minor's Name in Full _____ Date of Birth _____

Name of Adult Accompanying Minor _____ Date _____

I, _____ give authorization for _____

to receive medical care from Dr. _____ without a parent being present.

Please check one of the following:

- Is effective only on _____
- Is effective from _____ to _____
- Is effective until revoked in writing.

Witness _____ Parent/Legal Guardian _____

Date _____ Date _____

Contact numbers for parents:

Home _____

Work _____

Cell _____

Contact numbers for parents:

Home _____

Work _____

Cell _____