



I hereby give my permission to the physicians, and personnel of CarePointe Ear, Nose, Throat & Sinus to assess and treat the health needs of the patient named below. This permission included authorization for completion of outpatient diagnostic procedures as ordered by the physicians.

For Treatment of Minors

I understand that I should make every effort to accompany my child to appointments.

If I am unable to come to an appointment, I give permission for CarePointe physicians as follows (Choose One):

_____ I WILL ONLY ALLOW for the following named adults accompanying my child to consent for assessment/treatment:

_____ I DO NOT WISH TO ALLOW another caretaker who brings my child to CarePointe to sign for treatment.

_____ I UNDERSTAND that my child may not be seen if he/she arrives at the clinic with a caregiver that does not fit the above chosen guidelines.

_____ I UNDERSTAND that written permission signed by me will always be acceptable as consent for assessment/treatment.

(Patient's Name)

(Parent/Legal Guardian)

(Date)

(Witness)