Patient Last Name: _____ First Name: _____ DOB: _____

Designation of Authorized Adult to consent to Medical Treatment for Minor Patients

I do hereby state and represent that I have legal custody of the above-mentioned minor patient and that I have the authority to consent to all medical/surgical care of said minor. By signing below, I grant my authorization and consent for the Designated Adult(s) listed below to accompany the minor to Sinus and ENT Center of Texas-Tracy Byerly II MD PA locations for medical care and treatment.

I state and confirm that the Designated Adult(s) listed below are at least 18 years of age and competent to make medical decisions on my behalf. I authorize the Designated Adult(s) to consent to all treatment for the minor that is covered under Sinus and ENT Center of Texas-Tracy Byerly II MD PA consent to treat that I have previously signed, including, but not limited to, routine medical examination and treatment, immunizations, counseling, and in rare cases life saving measures.

I agree to assume financial responsibility for all expenses of the minor's medical care authorized by the Designated Adult(s). I understand that the healthcare provider, at his or her discretion, may require a parent or legal guardian to be present for certain non-emergent medical treatments, and in such cases, I may be required to accompany the minor.

I further understand that this authorization does not authorize the Designated Adult(s) to give written consent to the use or disclosure of the minor's protected health information, as those terms are defined by federal law.

I understand that I may change or revoke this authorization at any time by notifying the Sinus and ENT Center of Texas- Tracy Byerly II MD PA in writing.

The following individuals are Designated Authorized Adult(s):

First Name: _____ Last Name: _____ DOB: _____

DL Number: _____ State Issued: _____Phone Number: _____

Relationship to Patient: _____

First Name: _____ Last Name: _____ DOB: _____

DL Number: _____ State Issued: _____Phone Number: _____

Relationship to Patient: _____

First Name: _____ Last Name: _____ DOB: _____

DL Number: _____ State Issued: _____Phone Number: _____

Relationship to Patient: _____

Printed Name:	Legal Guardian Signature:	Date: