



ENTAA Care

Ear, Nose & Throat, Asthma & Allergy
Audiology & Hearing Aid Center
Speech & Balance Center

CONSENT FOR A MINOR TO RECEIVE MEDICAL TREATMENT WITHOUT THE PRESENCE OF A PARENT OR LEGAL GUARDIAN

Name of Patient: _____

- I hereby give my consent for the above named patient, who is of the age of 16 or greater, to receive medical treatment in the office of ENTAA Care, PA without being accompanied by a parent, legal guardian, or other adult.
- I hereby give my consent for the above named patient to receive medical treatment in the office of ENTAA Care, PA while being accompanied by an adult other than a parent or legal guardian (i.e., Grandparent, aunt/uncle, etc.).
- I **DO NOT** give consent for the above named patient to receive medical treatment in the office of ENTAA Care, PA without the presence of a parent legal guardian.

I also understand that a parent or legal guardian of a minor must be present to sign forms for annual record updates as well as consent forms for certain procedures or tests.

Signature of Parent or Guardian

Date

Relationship to Patient

Witness