HEARING RESOURCE CENTER OF SAN MATEO

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR WHEN LEGAL GUARDIAN and/or PARENT(S) ARE NOT PRESENT

Please print or type:

I/We, _____parent(s)/guardian(s) of _____, a minor, do hereby authorize the following individual(s);

(Please list names of legal adults only)

a. _____ d._____
b. _____ e. _____
c. _____ f. _____

as my agent(s) to consent to audiological evaluation, diagnosis and treatment, which are deemed advisable by and are to be rendered by or under the supervision of a licensed audiologist. It is understood that this authorization is given to provide authority and power on the part of my aforesaid agent(s) to give specific consent to any and all such procedures, which a licensed audiologist, in the exercise of his/her best judgment, may deem advisable. This authorization also grants to my agent(s) the power to sign for release of information to any third party payers who may be responsible for part or all of the cost of the services provided.

This authorization shall remain effective from _____/_____/_____ to_____/_____/_____, unless sooner revoked in writing delivered to said agent(s).

_____ _____/_____/_____
Signature of parent, guardian or other legal representative Date

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PATIENT INFORMATION FOR MINOR LISTED ABOVE

Patient's Name:_____ Date of Birth: _____/_____/_____
Current Medication(s):_____
Allergies:_____

Parent or Guardian Name(s):
(1)_____Relationship_____
(2)_____Relationship_____

Home Address:_____
Phone: _____Cell: _____ Other: _____