Lake Norman
Ears, Nose & Throat
Piedmont HealthCare

CONSENT FOR TREATMENT

I,_____, hereby authorize the medical personnel of

PHC Lake Norman Ears, Nose, and Throat to treat my child,_____,

If illness or injury occurs during my absence.

Please allow those listed below to seek medical attention for the child listed above:

1._____ _____ _____
(Name) (Telephone Number) (Relationship to Patient)

2. ._____ _____ _____
(Name) (Telephone Number) (Relationship to Patient)

3. ._____ _____ _____
(Name) (Telephone Number) (Relationship to Patient)

4. ._____ _____ _____
(Name) (Telephone Number) (Relationship to Patient)

5._____ _____ _____
(Name) (Telephone Number) (Relationship to Patient)

This authorization for treatment is valid until revoked in writing by Parent / Legal Guardian.

_____ _____
(Signature of Parent / Legal Guardian) (Date)

_____ _____
(Witness Signature) (Date)