SPOKANE VALLEY EAR, NOSE & THROAT AND FACIAL PLASTICS

ADVANCE CONSENT TO TREAT

I, _____, the parent or legal guardian of _____
Name of parent/legal guardian Name of patient

authorize _____, _____ to bring
Name of person(s) bringing patient (must be at least 18 years of age)

the patient to his/her appointment and give my consent to routine and emergency medical treatment for him/her when deemed necessary by qualified medical personnel.

This authorization will be in effect until revoked in writing by me.

_____ _____

Signature of parent/legal guardian Date