Delegate Authorized to Accompany Minor

_____ _____
Name of Child/Minor DOB:

As the parent/guardian of the above-named child/minor, I hereby appoint a delegate to consent to medical care when I am unable to personally attend and consent to treatment.

The following person(s) are authorized to accompany my child/children to their medical appointments at Ear, Nose and Throat Specialists of Wisconsin.

_____ _____
Name of substitute Relationship

_____ _____
Name of substitute Relationship

I also agree to be responsible to the provider(s) for charges for medical services rendered.

This authorization may be revoked at any time and will be in effect for one year from the date parent/legal guardian signed.

_____ _____
Parent or Guardian's Signature Date