EAR, NOSE, and THROAT
SPECIALISTS of WISCONSIN

AUTHORIZATION FOR DESIGNATED ADULT TO ACCOMPANY A MINOR

For appointments when someone other than a parent or legal guardian will bring the minor

Minor Patient Name _____	**Date of Birth** _____
Parent/Legal Guardian Name _____	**Provider (optional)** _____

Designated Adult

Designated Adult Name _____	**Relationship to Minor** _____	**Phone Number** _____
Alternate Designated Adult (optional) _____	**Relationship to Minor** _____	**Phone Number** _____

Parent/Guardian Authorization and Consent

I am the parent or legal guardian of the minor identified above and represent that I have legal authority to consent to the minor's health care. I authorize the designated adult named above to accompany my child to appointments at Ear, Nose & Throat Specialists of Wisconsin. I also authorize Ear, Nose & Throat Specialists of Wisconsin and its providers and staff to provide routine, non-emergency care during those visits, subject to the limitations below.

☐ The designated adult may discuss the child's symptoms, history, care plan, and instructions with the care team and may receive protected health information reasonably necessary to participate in the child's care and related follow-up.

☐ The designated adult may receive written visit instructions, school/work notes, medication instructions, and scheduling information related to the child's care.

Limitations on information or care (if any):

_____

_____

IMPORTANT: The designated adult is not being given independent authority by this form to make health-care decisions for the minor. If a parent/legal guardian cannot be reached and a new or material treatment decision is needed, the practice may delay non-emergency care until consent is obtained. If you want another person to have independent authority to consent to health care for your child, Wisconsin law provides a separate Power of Attorney Delegating Parental Power process under Wis. Stat. § 48.979.

Duration and Revocation

This authorization will remain in effect until I revoke it in writing, the patient reaches age 18, or the optional expiration date below occurs, whichever comes first. I may revoke this authorization at any time by notifying the practice in writing, except to the extent the practice has already relied on it. This authorization does not override a custody order, guardianship order, or other applicable law.

Optional expiration date: _____

_____ **Parent/Legal Guardian Signature**	_____ **Date**
_____ **Parent/Legal Guardian Printed Name**	_____ **Best Phone Number During Appointment(s)**