Ear, Nose and Throat Associates of Northern Colorado & The Hearing and Balance Clinic

Affiliated with Ear, Nose and Throat Associates of Northern Colorado

AUTHORIZED INDIVIDUALS TO ACCOMPANY MINORS

I hereby authorize one or all of the designated parties listed below to accompany my minor child to this medical office for appointments. I understand that if a medical procedure is to be performed that I as the patients Mother/Father or legal guardian must be present to sign a legal informed consent.

Authorized Designees:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Name: _____

Parent Name: _____

Parent Signature: _____ **Date**: _____

Bruce M. Smith M.D. **Meghan Abraham, Au.D., FAAA, CCC-A** **Amy Mullin Ph.D., CCC-A**

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