



David Mendelson, D.O., F.A.O.C.O.
Linda MacConnell, PA-C, MPAS

AUTHORIZATION FOR CONSENT TO TREAT A MINOR

I, _____, (name and relationship to minor) hereby consent to obtain the following medical treatment at ENT Specialists of Arizona, PC for _____ (name of minor and date of birth).

Please check one _____ all surgical and medical treatment
_____ only the surgical and or/medical treatment listed below

Name of treatment

The authorization shall be limited to the following time period: _____
if no time period is designated, this authorization shall terminate one year from today's date.
I accept responsibility for all charges related to any medical treatment rendered by reason of this authorization.

Signature: _____ Date: _____
(must be signed by parent or legal guardian)