Arthur Rosner, MD
Ear, Nose & Throat Specialist
Board Certified in Otolaryngology and Sleep Medicine

- Otolaryngology
- Head & Neck Surgery
- Ear, Nose & Throat
- In-Office Balloon-Sinuplasty
- Hearing Aids
- Sinus Specialist
- Pediatrics & Adults
- Sleep Apnea Surgery

Authorization to Treat Minor Patient in Absence of Parent/Guardian

I, _____, the parent and legal guardian of _____,
(name of parent/guardian) (name of child)

hereby authorize _____ to accompany my above-named child to office visits
(name of adult accompanying child to office)

with _____ and consent to the examination and/or treatment of
(name of physician/physicians)

of my child during the office visits.

This authorization:

☐ Is effective only on _____ (month/day/year).

☐ Is effective from _____ to _____ month/day/year.

☐ Is effective until revoked by me in writing.

I reserve the right to revoke this authorization at any time by writing to the above named physician. I understand that my child (under 18 years of age) cannot attend his/her appointment without the accompaniment from the adult listed above.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Witness Date