SOUTH FLORIDA
ENT ASSOCIATES

PARENTAL (OR GUARDIAN) CONSENT

I, _____, parent (or guardian) of minor child (or incapacitated person) _____ (hereinafter referred to as patient) do hereby consent to the treatment of patient by South Florida ENT Associates, P.A.

If further consent is required and I am not available I hereby authorize _____, the _____ of the patient to consent.

_____
Patient's name

_____ _____
Parent Signature (or guardian) Date

_____ _____
Witness Date