Spokane Valley Ear, Nose Throat & Facial Plastics

Authorization for Non-Parent Consent for Treatment of Minor Child

Please fill out this form if your child will be coming for a visit, treatment, or procedure, accompanied by someone other than a parent or legal guardian. This agreement will stay in effect for one year from the date of signature below unless revoked in writing by a parent or legal guardian.

This agreement does not involve approval for routine child and adolescent shots

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Printed Name of Minor Child Date of Birth

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Printed Name of Person Approved to Seek Medical Care for the Above-Named Minor Child

I approve the above-named person to seek health care for my minor child listed above. I know that I am financially responsible for all health care fees incurred by my child during these visits.

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Printed Name of Parent/Legal Guardian Signature of Parent/Legal Guardian

☐ Primary Custody ☐ Shared Custody ☐ Sole Custody

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Date of Signature Phone Number of Parent/Legal Guardian

For Foster Care:

I approve the above-named person to seek health care for the minor child listed above. Financial duty for health care fees owed during these visits is outlined in the foster care records.

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Printed Name of Court Chosen Case Manager Signature of Case Manager

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Date of Signature Phone Number of Case Manager