GK ENT GREATER KNOXVILLE EAR NOSE & THROAT

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MEDICAL CONSENT FORM

Only complete this form if patient is under the age of 18.

Patient Name: _____

Are you the legal guardian for this patient? ☐ YES ☐ NO

I hereby give my consent for the following individuals to bring my child/children to:

Greater Knoxville Ear, Nose and Throat Associates, P.C.

For treatment of illnesses or injuries in my absence. This agreement will remain in effect until I authorize cancellation by having this consent form removed from the chart.

Signed: _____
Parent or Legal Guardian

Witness: _____

Below are the names, relationships and telephone contact numbers whom may accompany my child/children to Greater Knoxville Ear, Nose and Throat Associates, P.C.

PERSON(S) AUTHORIZED RELATIONSHIP PHONE NUMBER

_____

_____

_____

_____

_____

DATE: _____