Hoover
Ear, Nose and Throat
Associates, P.C.
2116 Data Park
Hoover, AL 35244
205-733-9595
205-733-9599 Fax

Hoover Hearing Clinic
A division of
Hoover ENT Associates, P.C.
2116 Data Park
Hoover, Alabama 35244
205-733-9694 Tel
205-733-9599 Fax

Consent for Medical Treatment of a Minor Child

When you are away from your child, the person entrusted with your child's care for an illness or injury should be listed below. **We cannot medically treat your child without your written permission**. Please list below the adult person or persons that have your consent to seek medical care for your child in your absence.

I, _____ give permission for the adult or adults listed below to seek medical treatment for my child _____ (Date of birth _____) in my absence:

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

This permission is valid from the dates of _____ to _____ for the office of Hoover Ear, Nose & Throat Associates, P.C. and /or Hoover Hearing Clinic (*a division of Hoover ENT Associates, P.C.*), 2116 Data Park, Hoover, AL 35244.

_____ _____
Parent's/Guardian's Signature Date

_____
Printed Name of Parent/Guardian

_____ _____
Signature of Witness Date

Consent to Discuss Financial Information

Unless we have written permission we will not discuss financial information with anyone other than the person responsible for the account as per our financial policy. If there is anyone who has your permission to discuss this information with our insurance billing office, such as a caretaker, step-parent or a grandparent, please list this person or persons below. **Please know that, as always, the person who accompanies the patient is responsible for the bill or co-pay at the time of visit.**

Name _____ Relationship _____

Name _____ Relationship _____

Signature of Responsible Party _____ Date _____