Bluegrass Ear, Nose & Throat Clinic, PSC
Bluegrass Hearing Institute, PSC
General Otolaryngology • Allergy & Sinus Disease • Audiology & Hearing Aids
Clark Clinic B • 225 Hospital Drive, Suite #265 • Winchester • Kentucky • 40391
☎: 859-745-1010 / 866-966-7468 • Fax: 859-745-0080 • www.bluegrassentclinic.com

Dear Parent/Guardian,

In a continued effort to serve our patients and look out for their best interests, we are asking that the attached form be completed and returned to our office on or before your child's next visit.

If in the event that the child is to have an in-office procedure or testing completed, we ask that the person accompanying the child have all the child's medical history and information. In the case he/she is unable to answer required questions, the appointment may need to be rescheduled until a parent or guardian can be present.

Our office will also contact you upon receipt of this document just as a secondary validation that all the information is clearly understood, current and correct.

If you have any questions or concerns, please feel free to contact our office at the number listed above at Extensions **#21** or **#25**.

Sincerely,

Patient Services

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DESIGNATION OF ANOTHER PERSON TO CONSENT FOR MEDICAL CARE

I, (parent/legal guardian) _____, cannot accompany my child, (child's name) _____ (DOB: _____/_____/_____), to **Bluegrass Ear, Nose and Throat Clinic, PSC**. Therefore, I give permission to (person's name) _____ as follows:

I give permission for this person to accompany my child to visits at Bluegrass Ear, Nose and Throat Clinic, PSC <u>without the need</u> to contact me directly. They may act on my behalf in regards to in-office treatment, procedures or testing that my child may receive.

Expiration of Permission (check one):

❑ This form will remain in effect until revoked by me by contacting the physician office.

❑ This form is **VALID ONLY** during the following timeframe:

Effective date: _____/_____/20____ / Expiration Date: _____/_____/20____

×_____ _____/_____/20_____
Signature: ❒ Self ❒ Mother ❒ Father ❒ Guardian Date Signed

×_____
Name of Patient or Guardian/Responsible Party (PRINT)

×_____ _____/_____/20_____
Signature of Witness Date Signed

Address: _____

Home Phone: _____-_____-_____ / Work Phone: _____-_____-_____

For Official use Only:

Date Confirmation Call Made: _____/_____/20____ / By: _____

Spoke with: _____