Roseville Diagnostic Hearing Center, LLC
1411 Secret Ravine Parkway, Suite 120
Roseville, CA 95661

Consent to Provide Treatment for a Minor Child When Legal Guardian and/or Parent(s) are NOT Present

This form allows someone other than a parent or legal guardian to make medical decisions for a minor child as if they were the parent. Please be advised that protected health information may be shared with the accompanying adult to facilitate informed decision making.

I/We, _____parent(s)/guardian(s) of _____, a minor, give consent and authorization for the following individual(s) named below as my agent(s) to consent to audiological evaluation, diagnosis, treatment and/or care to be rendered to the above named minor child by a licensed audiologist or under the supervision by a licensed audiologist. This authorization also allows my agent(s) the power to sign for release of information to any third-party payers who may be responsible for part or all of the cost of the services provided. I (we) understand that any balance remaining after insurance approves or denies payment is my responsibility to pay.

(List Names of accompanying adults)

1. **Name**:_____
   Phone: _____
   Relationship to the child: _____
2. **Name**: _____
   Phone: _____
   Relationship to the child: _____

This consent is valid until it is revoked by the parent(s) or legal guardian(s). This authorization shall remain effective from _____ to _____.

Child's Name:_____ **Date of Birth**: _____

Parent or Guardian Name(s): _____ **Relationship**: _____

Contact Phone:_____

Home Address:_____

Parent or Guardian Name(s): _____ **Relationship**: _____

Contact Phone:_____

Home Address:_____