

Charles C. Greene, MD, PhD

www.jacksonvilleENTsurgery.com

MAIN OFFICE

11512 Lake Mead Ave Ste #536 Jacksonville, FL 32256 (904) 419-2054 (Ph) (904) 419-2057 (Fax)

SATELLITE OFFICE 4131 University Blvd S #18

Jacksonville, FL 32216 (904) 419-2054 (Ph) (904) 419-2057 (Fax)

SATELLITE OFFICE

3890 Dunn Ave Ste #202 Jacksonville, FL 32218 (904) 419-2054 (Ph) (904) 419-2057 (Fax)

SATELLITE OFFICE

6484 Ft Caroline Rd Jacksonville, FL 32277 (904) 419-2054 (Ph) (904) 419-2057 (Fax)

SATELLITE OFFICE

789 W. Duval St Lake City, FL 32055 (904) 419-2054 (Ph) (904) 419-2057 (Fax)

Consent for Treatment of a Minor

consent.				
Minor's Name:	DOB:	Relat	tionship:	
Signature of Parent or Legal Guardian)		(Date)		
	Consent by Parei	nt/Legal Gua	<u>ırdian</u>	
, the undersigned, as the parent or legal	guardian of		(the "minor") have	e the legal
uthority to give consent for the treatme				
ninor as may be considered necessary or	r appropriate under the circu	imstances for the tr	eatment of any medical condition	n. I agree that
reatment may be provided in my absend	ce. This consent shall remain	in effect unless rev	oked in writing.	
Conco	at by Minar Datio	a+ /	d -!	
Consei	<u>nt by Minor Patier</u>	it (under ilmite	<u>a circumstances)</u>	
, c	onsent to such diagnostic, m	edical and/or surgio	cal treatment by Jacksonville ENT	Surgery. I have
				Surgery. I have
he legal authority to consent to such tre	atment because I am (check	one or more of the		
he legal authority to consent to such tre □an emancipated minor (eman	atment because I am (check cipated by court (must provi	one or more of the	following):	
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