Charles C. Greene, MD, PhD
www.jacksonvilleENTsurgery.com

MAIN OFFICE	SATELLITE OFFICE	SATELLITE OFFICE	SATELLITE OFFICE	SATELLITE OFFICE
11512 Lake Mead Ave Ste #536	4131 University Blvd S #18	3890 Dunn Ave Ste #202	6484 Ft Caroline Rd	789 W. Duval St
Jacksonville, FL 32256	Jacksonville, FL 32216	Jacksonville, FL 32218	Jacksonville, FL 32277	Lake City, FL 32055
(904) 419-2054 (Ph)	(904) 419-2054 (Ph)	(904) 419-2054 (Ph)	(904) 419-2054 (Ph)	(904) 419-2054 (Ph)
(904) 419-2057 (Fax)	(904) 419-2057 (Fax)	(904) 419-2057 (Fax)	(904) 419-2057 (Fax)	(904) 419-2057 (Fax)

Consent for Treatment of a Minor

According to Florida Law, a parent or legal guardian must consent to the treatment of a minor (any person under 18 years of age) except under certain circumstances. The exceptions are listed below under the Consent by Minor section. In circumstances when the minor has the legal right to consent, Florida Law prohibits the release of the minor's medical records for such treatment without the minor's written consent.

Minor's Name:_____DOB:_____Relationship:_____

_____ _____

(Signature of Parent or Legal Guardian) *(Date)*

Consent by Parent/Legal Guardian

I, the undersigned, as the parent or legal guardian of _____(the "minor") have the legal authority to give consent for the treatment of this minor. I, hereby authorize such diagnostic, medical and/or surgical treatment of such minor as may be considered necessary or appropriate under the circumstances for the treatment of any medical condition. I agree that treatment may be provided in my absence. This consent shall remain in effect unless revoked in writing.

Consent by Minor Patient (under limited circumstances)

I, _____, consent to such diagnostic, medical and/or surgical treatment by Jacksonville ENT Surgery. I have the legal authority to consent to such treatment because I am (check one or more of the following):

- □ an emancipated minor (emancipated by court (must provide court order), or I do not reside with my parents and I am financially independent). I can consent to any treatment.
- □ married, divorced or widowed (must provide copy of court document). I can consent to any treatment.
- □ a mother consenting to treatment of my child. (ex. Minor consenting to have their child treated by a Physician)

_____ _____

(Signature of Minor Patient) *(Date)*

Consent by Minor for Release of Medical Information of Treatment that Minor Provided Consent

Often times we are asked to give family members or others information on test results, etc. especially if you are not available to receive them. If you would like us to give out information regarding your treatment and/or test results to family or friends, please fill in their relationship to you and their name and check which type of information each person may receive. **If you do not allow us to discuss with the person financially responsible for your treatment, you, the minor, are responsible for payment in full prior to any testing and/or procedures.**

Name	Relationship			
		□ ALL INFO	□Labs and/or Procedures	□ Appts
		□ ALL INFO	□Labs and/or Procedures	□ Appts
		□ ALL INFO	□Labs and/or Procedures	□ Appts

□ **I consent to the provider sending a bill and discussing the service provided to my parent or guardian who is responsible for payment.** (Checking the box provides your consent to this statement.)

By signing this agreement, I acknowledge that I have carefully read, understand and agree to the above terms and conditions.

_____ _____

(Signature of Minor Patient) *(Date)*