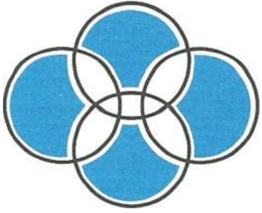

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Sue M. Bain, AuD.
Audiologist

AUTHORIZATION FOR TREATMENT

I ___________________________________, give my permission for the following adult(s) to bring my child, ________________ ______________, in for visits. I am giving my permission and I authorize the person(s) listed below to bring my child in for medical treatment.

__________________________Relationship___________________

__________________________Relationship___________________

__________________________Relationship___________________

__________________________Relationship___________________

Signature:____

Parent/Legal Guardian