FLORESVILLE
830.542.8957
FAX: 830.542.8958
1605 US HWY 181 N.
Suite A
Floresville, TX 78114

DOSS AUDIOLOGY
& HEARING CENTER

SCHERTZ
210.819.5002
FAX: 210.819.5003
645 Woodland Oaks Drive
Suite 350
Schertz, TX 78154

DESIGNATION TO CONSENT FOR MEDICAL CARE

I, (parent/legal guardian) _____, cannot accompany my

child, *(child's name)* _____, to Doss Audiology & Hearing Center.

Therefore, I give permission to *(person's name)* _____ as follows:

☐ I give permission for this person to seek diagnostic testing and receive testing results for my child.

☐ I give permission for this person to sign new patient paperwork and provide case history information to the best of their knowledge.

Expiration of Permission (check one):

☐ This form will remain in effect until revoked writing.

☐ This form is VALID ONLY during the following timeframe:

Effective date: _____ Expiration date: _____

_____ _____

Signature Of Parent Or Legal Guardian **Date**

**FORM MUST BE SUBMITTED WITH COPY OF VALID PARENT/LEGAL GUARDIAN PHOTO ID*