Rocky Mountain
EAR CENTER, P.C.

OTOLOGY/NEUROTOLOGY
David C. Kelsall, M.D., P.C.

AUDIOLOGY
Allison Biever, Au.D., CCC-A
Katie Breithart, Au.D., CCC-A
Robin Humphrey, Au.D.

ROCKY MOUNTAIN COCHLEAR IMPLANT CENTER
Phone 303.806.6293
Johnnie Herman,
Administrative Assistant

Medical Plaza I
601 E. Hampden Avenue
Suite 530
Englewood, CO 80113
Phone 303.783.9220
Fax 303.806.6292

www.rockymountainearcenter.com

PARENTAL CONSENT FOR MEDICAL CARE

Child Name: _____
Birth date: _____
Social Security Number: _____
Address: _____

The undersigned(s) being the lawful parent(s) and/or guardian(s) of the above child (the "Child"), hereby consents to medical care at Rocky Mtn Ear Center PC, by Dr. David C. Kelsall and his staff on _____ through _____.

Health care provided at Rocky Mtn Ear Center PC shall include but not be limited to the taking of pertinent history, head and neck examination, performance of microscopic ear examination and cleaning of ear canal, diagnostic testing, and other procedures as deemed necessary.

If there is no medical emergency and more complex procedures are required, the staff at Rocky Mtn Ear Center PC will first use reasonable efforts to contact the parent(s) and/or guardian(s) before administering more complex treatment.

This Consent Form may be revoked at any time before the expiration date with written notice to Rocky Mtn Ear Center PC.

Signed on _____ (date)
at _____ (city), _____ (state).

_____
Signature of Parent

_____
Signature of Parent