Date: _____

Patient Name: _____

PERMISSION TO CONSENT FOR MEDICAL/OPTOMETRIC CARE TO MINOR CHILD OR INCAPACITATED ADULT

The parent(s) or legal guardian of the following minor child or incapacitated adult:

Name of Patient	**Date of Birth**	**Insurance Type and Number**
_____	_____	_____

Please bring the patient's insurance card to the visit.

Authorize:

A primary person and an alternate are recommended.

Name of authorized person	Address	Telephone
_____	_____	_____
Primary		
_____	_____	_____
Secondary		

To consent to an examination which may include dilation, contact lens fitting (including contact lens class and all subsequent follow-ups), diagnosis and/or treatment to be rendered to the patient on the advice of any Optometrist licensed to practice Optometry.

This authorization shall be effective for six (6) months from the date signed.

Signatures:

The signature and consent of <u>one</u> parent is sufficient.
Guardian: please attach copy of <u>Letters of Guardianship.</u>

_____	_____
Parent/Guardian	Date
_____	_____
Print Name	Primary Phone