Authorization for Treatment of a Minor

I authorize the providers at Associates In Eyecare to examine, diagnose, and treat the person listed below, for whom I am legally authorized to give consent. I authorize such services that the provider feels are necessary or advisable and are rendered under the provider's general or specific instructions.

Patient Name _____ Birth Date _____

Parent/Legal Guardian Signature _____ Date _____

Parent/Legal Guardian Name (Print) _____

Relationship to Patient _____

Witness Signature _____ Date _____