CRYSTAL VISION CLINIC

Authorization to Treat Minor Patient in the Absence of Parent/Guardian

I certify that I am the parent and/or legal guardian of:

Name of minor patient: _____ Date of Birth: _____

Please select the option that best applies:

❑ I authorize the above named minor to come alone to office visits at Crystal Vision Clinic.

❑ I authorize _____

(name of person bringing child to office)

to accompany the above named minor to office visits at Crystal Vision Clinic.

I consent to the examination and/or treatment of the above named minor in my absence.

The exam may include dilation of the eyes, please check one of the following:

❑ YES - I consent to dilation, if the doctor deems it necessary

❑ NO- I do NOT consent to dilation today.

*Certain medical conditions may go undetected if dilation is not performed. Please speak to one of our staff or your eye doctor, if you would like further information.

This authorization is effective (Please select one of the following):

❑ This date only _____

❑ From this date _____ to this date _____

❑ Until revoked by me in writing

PRINTED Parent/Legal Guardian Name _____

Preferred phone: _____ Alternate phone: _____

I reserve the right to revoke this authorization at any time by contacting Crystal Vision Clinic in writing.

Parent/Guardian Signature: _____ Date: _____