Patient Name: _____ Account #_____ Guarantor / Guardian Name: _____

AUTHORIZATION FOR EXAMINATION (MINORS)

Unless a court has stated otherwise (and a formal legal document can be provided to us), the parents listed on the birth certificate are the only people allowed to approve medical care being provided to a child. If a parent or LEGAL guardian isn't bringing the child to his/her appointment, then we need permission from the parent that we can see that child. Please complete the following Information to authorize us to see your child with the following people you would like to be able to bring your child to appointments.

I, the parent/guardian, give the physicians and clinical staff permission to examine, instill drops and administer necessary tests to the following patient(s) without my presence. I swear that the information below is correct, and that I am the parent/legal guardian of the below-mentioned patients.

I AUTHORIZE the following people to bring my child(ren) to see the doctors of Pediatric Ophthalmology, PA:

NAME: _____RELATIONSHIP (TO CHILD) _____ DOB: _____

NAME: _____ RELATIONSHIP (TO CHILD) _____ DOB: _____

My following child(ren) are allowed to be escorted to his/her appointments by the above-mentioned people:

PATIENT'S NAME: _____ DOB: _____ PATIENT'S NAME: _____ DOB: _____

PATIENT'S NAME: _____ DOB: _____ PATIENT'S NAME: _____ DOB: _____

PARENT/GUARDIAN NAME: _____ SIGNATURE: _____

DAY-TIME PHONE NUMBER: _____ ALTERNATE PHONE NUMBER: _____

CONTACT INFORMATION OF ANOTHER PARENT/LEGAL GUARDIAN IF I'M UNABLE TO BE REACHED DURING THE PATIENT'S EXAM

NAME: _____ RELATIONSHIP: _____

PHONE NUMBER: _____ ALTERNATE PHONE NUMBER: _____