LAKE EYE ASSOCIATES

A US EYE COMPANY

Person Number (office use only): _____

Permission to Treat a Minor

Lake Eye Associates must receive permission from a child's parent or legal guardian before providing treatment for any injury or illness that is non-life threatening. This form gives our office the legal permission and consent to treat your child in case you cannot accompany him/her. Please sign and return this form to our office **PRIOR TO YOUR CHILD'S APPOINTMENT** should you wish to authorize treatment without a parent/guardian being present.

Name of Minor Patient: _____ DOB: _____

☐ **CONSENT TO PERMIT CERTAIN INDIVIDUALS TO ACCOMPANY CHILDFOR TREATMENT:**

I, _____(Name of Parent/Guardian), hereby authorize the following individual(s) to accompany my child to Lake Eye Associates for the provision of medical services, and to view or discuss my child's Protected Health Information (PHI).

Please list those individuals who may accompany your child.

Name	Relationship	Phone

☐ **CONSENT TO TREAT UNACCOMPANIED MINOR AT LAKE EYE ASSOCIATES**

I, _____(Name of Parent/Guardian), authorize for my child to attend his/her appointment alone without my presence and authorize Lake Eye Associates and it's personnel to deliver medical care to my minor child listed above.

Parent/Guardian Contact Information

Parent/Guardian Name: _____ Parent/Guardian Name: _____

Relationship to Patient: _____ Relationship to Patient: _____

Phone: _____ Phone: _____

My signature below indicates my understanding of this form and approval. I agree to be available by phone and to be financially responsible for all copays and coinsurances.

This authorization is effective on: _____ and expires on _____.

_____ _____

Signature of Parent/Guardian* Date

_____ _____

Printed Name of Patient/Guardian* Relationship to Patient*