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:

HIPAA requires a separate form for each patient.

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		
Alternate		

to consent to an examination which may include dilation, contact lens fitting (including contact lens class and all subsequent follow-ups), vision therapy (VT 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 from the date signed through _____--_____,20___, which must not exceed six(6) months from the date signed.

Signatures:

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

_____ _____

Parent/Guardian Date

_____

Print Name Telephone(_____)_____ _____