CARL E. FLINN, MD
PEDIATRIC OPHTHALMOLOGY & ADULT STRABISMUS
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CONSENT TO MEDICAL TREATMENT FOR A MINOR

Today's Date: _____

I, _____, (parent/guardian) grant permission to _____ (adult accompanying patient), to make medical decisions regarding the treatment of _____ (patient). The aforementioned adult has my permission to discuss medical treatment plans and actions and provide necessary medical history with Dr. Flinn and his staff. This letter will be valid for one year from _____ (mm/dd/yy).

Patient's Name: _____ Patient's DOB: _____

Parent/Guardian's Printed Name: _____ DOB: _____

Parent/Guardian's Signature: _____
Valid phone number that our office can use if we need to contact the above parent/guardian:
_____

Please include this form with the completed paperwork packet on our website. If the paperwork is not complete in full, we will not be able to see the patient. The adult listed above accompanying the patient must also have a valid ID and be prepared to make any payments due at the time of the visit. If you have any questions, please call our office at the number listed above.