

AUTHORIZATION FOR EXAMINATION OF MINORS WHEN PARENTS/LEGAL GUARDIANS ARE NOT PRESENT

If a Parent or Legal Guardian cannot accompany their child to the doctor, ***WE MUST HAVE*** written authorization from them in order to examine that child. Please complete the following information to authorize us to examine your child in your absence. The accompanying adult must show a valid ID when they arrive with your child.

I, the parent/legal guardian of the below named patient(s), give the doctors and staff of Pediatric Eye Associates, LLC permission to examine and treat my child(ren). I authorize the adult(s) listed below to accompany and make decisions regarding my child(ren):

1. Patient: _____ DOB: _____

2. Patient: _____ DOB: _____

3. Patient: _____ DOB: _____

1. Accompanying Adult: _____

Relationship to patient: _____

2. Accompanying Adult: _____

Relationship to patient: _____

Exam date: _____

Authorization Expiration date: _____

Parent/Legal Guardian Mobile/Work Phone: _____

Parent/Legal Guardian Home Phone: _____

Parent/Legal Guardian Name: _____

Parent/Legal Guardian Signature: _____