



EYE SPECIALISTS

● 1103 Galvin Road South, Suite H Bellevue, NE 68005 PH: 402-292-6514 ● 9910 S 71st Plaza, Suite 103 Papillion, NE 68133 PH: 402-933-0708

Consent to Treat Minor Patient - Without Parent/Legal Guardian Present

By law, any child under the age of 19 years of age cannot be seen by a doctor without consent from a parent or legal guardian. If the minor arrives with someone other than a parent or legal guardian, we must have written permission from the parent or legal guardian that this person has been appointed by you to act on your behalf.

Minor's Name: _____

DOB: _____

For those occasions when you may not be with your child, **please list those individuals who may give us consent to see your child:**

Name _____ Relationship _____

Name _____ Relationship _____

LIMITATIONS

Identify any specific limitations on the kinds of medical services for which this authorization is given.

None Limitations: _____

Check here if you wish to give consent for the minor to receive medical care **without an accompanying adult**. This consent may only apply to **minors age 16 and older**.

This consent shall be in effect for: Date _____ ONLY

Indefinitely, until revoked ny written communication

AUTHORIZATION

I (parent/legal guardian name) _____ request and authorize Eye Specialists and its personnel to deliver medical care to my child listed above as deemed necessary or advisable in the diagnosis and treatment of the minor child.

I have the legal right to preauthorize Eye Specialists and its personnel to deliver medical treatment and services to my child.

I have read, understand and give my consent as stipulated above. My signature means that I have read this form and/or have had it read to me and explained in the language that I can understand.

Parent or Legal Guardian (PRINTED NAME)

Date

Parent or Legal Guardian (SIGNATURE)

Date