The EyeClinic
Diseases & Surgery of the Eye

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CONSENT FOR EXAMINATION / TREATMENT OF A MINOR WITHOUT THE PRESENCE OF A PARENT OR LEGAL GUARDIAN

PATIENT:_____**D.O.B.**_____**AGE**_____

DATE OF VISIT_____ **TIME**_____ **DR.**_____

Eye Clinic Location – Check one:
Lake Charles___ Sulphur___ DeRidder___ Jennings___ Moss Bluff___ 1st Ave___

*****Complete section A, B or C**

A) A minor will accompany a minor----
As the above patient's Parent / Legal Guardian (circle one) , I authorize _____, who is a minor, to accompany _____ to The Eye Clinic/Optics Unlimited for an eye examination (dilated or undilated), office visit, diagnostic testing, contact lens/glasses fitting, etc.

B) An adult will accompany a minor----
As the above patient's Parent / Legal Guardian (circle one), I authorize _____ to accompany_____to The Eye Clinic/Optics Unlimited for an eye examination (dilated or undilated), office visit, Diagnostic testing, contact lens/glasses fitting, etc.

Minor will not be accompanied by Parent / Legal Guardian or anyone else------
As the above patient's Parent / Legal Guardian (circle one), I authorize The Eye Clinic and/or Optics Unlimited staff to perform a complete exam (dilated or undilated), routine check-up, diagnostic testing, contact lens/glasses fitting, etc. without my presence and without the presence of another person.

*****Complete this section if** you want The Eye Clinic / Optics Unlimited to release medical information regarding minor to someone other than the Parent / Legal Guardian.

I authorize The Eye Clinic/Optics Unlimited staff (doctor, nurse, technician, etc.) to release medical and/or any other information regarding the patient to _____.

Expiration Date of this form (Check one):
_____ Immediately following this visit
_____ Specified date:_____
_____ Indefinitely

Notes/Comments:
_____

_____
Signature

_____
Print

_____
Date

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