West Metro
OPHTHALMOLOGY

Authorization For Evaluation And/Or Treatment of a Minor Child
Unaccompanied by Parent or Legal Guardian

A parent or legal guardian must accompany a child younger than 18 years of age to consent for all medical and/or surgical treatment provided by West Metro Ophthalmology. Please complete this form if your child will be coming for a visit, treatment, or procedure, without a parent or legal guardian. This consent is valid for the specified time period witih a maximum of one year from date signed.

Minor Patient:	Name:		
	Address:		
	City:	State:	Zip:
	Date of Birth:	Phone:	
Time Period:	Written consent is valid for the time period of: _____ to _____. (Not to exceed one year) at which time a new consent form will be required. This consent may be removed by me at any time in writing.		
Authorization for other individual to accompany minor patient under 18 years of age.	Name of person I authorize:	Date Signed:	
	To give consent to medical treatment by West Metro Ophthalmology on behalf of my child listed above. The above-named individual may also receive test results and additional information pertinent to the care and treatment of this minor child. I understand that I am still financially responsible for all medical expenses incurred by my child during these appointments.		
	Signature of Parent/Legal Guardian:	Date Signed:	
	Phone Number(s) in case of emergency:		
Authorization for minor patient to be unaccompanied for treatment by West Metro Ophthalmology.	I authorize and give consent for my child, listed above, to go independently to appointments and consent to all medical and/or surgical treatment without the presence of a parent or legal guardian. I understand that I am still financially responsible for all medical expenses incurred by my child at these appointments.		
	Signature of Parent/Legal Guardian:	Date Signed:	
	Phone Number(s) in case of emergency:		

PLEASE HAVE AUTHORIZED INDIVIDUAL PRESENT THIS FORM FOR EACH VISIT.