

Parent or Guardian Consent to Treat Minor

I understand that Tri-County Eye Physicians & Surgeons, PC has a policy regarding parental or guardian presence during an examination or treatment of my minor child.

I would like to give my written authorization for the examination/treatment without my presence.

I would also like to give my permission for my authorized representative (named below) to be present during the examination/treatment of my minor child. (over 18 yrs.)

PATIENT NAME _____

AUTHORIZED REPRESENTATIVE _____

RELATIONSHIP _____

PARENT NAME _____

SIGNATURE _____

Fax Back to 215-355-0790 Attention: Judi Howard, Patient Relations Manager/Southampton
Fax Back to 215-230-9994 Attention: Patti Hischmann, Patient Relations Manager/New Britain