Date: _____

Professional Eye Associates

Parental Pre-Authorization for Medical Care to Children

I (we) request and authorize the Practice and its personnel to deliver medical care to my (our) child listed below:

Name: _____ Date of birth: _____

Please try to contact me (us) regarding the healthcare of my (our) child at the following number(s):

Parent's name: _____

Phone (office/home): _____

Parent's name: _____

Phone (office/home): _____

Other (relationship): _____

Phone (office/home): _____

Signature: _____

Date: _____

Print name and relationship: _____

Please list the name, relationship and phone number of any other people who are authorized to bring your child in for an appointment. Please note that if a minor is brought in by anyone not authorized to seek medical treatment for the child, we will need to reschedule the appointment.

_____

_____

_____

NOTE: *If any special parental or custodial relationship (such as custody with one parent only, legal custody/guardians with no parent, etc.) is in place, please explain in the space below with your signature, printed name, and a phone number at which you can be contacted.*

_____

_____

Signature: _____

Printed name: _____

Phone: _____