



CONNECTICUT EYE CONSULTANTS
CONSENT TO TREAT MINOR/DEPENDENT PATIENTS

Connecticut Eye Consultants policy states any child under the age of 18 years old cannot be seen by one of our Providers 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.

Patient

Name: _____ **DOB:** _____

Address: _____

For those occasions when you may not be with your child/dependent, please list those individuals who may give us consent to treat the patient:

_____ Accompanying Adult	_____ Relationship to Patient	_____ Phone #
_____ Accompanying Adult	_____ Relationship to Patient	_____ Phone #
_____ Accompanying Adult	_____ Relationship to Patient	_____ Phone #

~This authorization is in force until either the minor reaches the age of 18 or unless revoked in writing.

AUTHORIZATION:

I (parent/legal guardian name-please print) _____ request and authorize Connecticut Eye Consultants to provide all medically necessary care to the above patient. I am also aware that the accompanying adult is responsible for all copays due at the time of service. I have the legal right to authorize Connecticut Eye Consultants and its' staff to deliver medical treatment and services to above patient.

I have read, understand and give my consent to the above.

_____ Parent/Legal Guardian (Signature)	_____ Relationship	_____ Date of Birth	_____ Date
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Contact phone # _____

Rev 8/24