Minor Consent Form

Patient Information

- Minor Patient Name: _____ Date of Birth: _____
- Date of Appointment: _____

Parent / Legal Guardian Authorization

I, _____ (Parent/Legal Guardian Name), am the parent or legal guardian of the above-named minor patient.

I hereby authorize the following adult to accompany my child to their ophthalmology appointment and to consent to routine eye care, examinations, diagnostic testing, and treatments deemed medically necessary by the provider during this visit.

I understand that this authorization **does not** include consent for surgical procedures unless otherwise specified in writing. I confirm that the above information is accurate and that I grant permission for the authorized adult named above to accompany my child and consent to care as described.

Authorized Adult Information

- Authorized Adult Name: _____
- Relationship to Minor: _____
- Phone Number: _____

By signing below, I acknowledge that I am authorized by the parent/legal guardian to accompany the minor patient and act on their behalf for today's visit.

Authorized Adult Signature: _____ Date: _____

Office Use Only – Staff Verification

I confirm that I spoke directly with the parent/legal guardian listed above and verified authorization for the minor patient to be accompanied by the authorized adult.

- Name of Employee: _____
- Method of Verification: ☐ Phone ☐ In Person ☐ Other: _____
- Date & Time of Verification: _____

Employee Signature: _____