Permission to Examine and Treat a Minor

Patient Name: _____ DOB: _____

I give my permission to examine and treat the above named individual by practitioners and staff at Puget Sound Eye Care and Optical Solutions. I understand that I am responsible for the charges for the goods and services provided. I am aware that I am able to revoke this authorization at any time by written correspondence to Puget Sound Eye Care.

_____
Parent/Legal Guardian Signature

_____
Printed Name

_____
Date

_____
Relationship to Patient
(Parent, Legal Guardian, Personal Representative)