**CLEVELAND VISION CENTER**
**CONSENT TO TREAT MINOR PATIENT**

This form provides authorization by a parent or legal guardian for another adult to consent treatment of a minor during the absence of the parent(s) or legal guardian. This form may be on file with the office prior to a scheduled appointment or presented at the time of an appointment.

**Minor's Information**:

_______________________________________________________________________________

Last First Middle

____________________________________ ______________________________________

Patient Date of Birth: mm/dd/yyyy Parent E-mail

Allergies:_____________________________________________________________________

Current Medications: ___________________________________________________________

_______________________________________________________________________________

Chronic Conditions or Health Concerns: ___________________________________________

List the individuals who are authorized to accompany and consent for treatment of the minor, for example a grandparent, caregiver, or adult sibling:

_______________________________________________________________________________

Name Relationship to Patient

_______________________________________________________________________________

Name Relationship to Patient

• I pre-authorize Cleveland Vision Center and its personnel to deliver routine vision care and services to the minor when accompanied and/or consented by an individual listed on this form. Further consent from the parent or legal guardian may be necessary if a procedure requires an informed consent.

• I understand that the insurance information must be presented at the time of the appointment and the adult accompanying the minor is responsible for payment of the patient portion at the time of service.

• I understand I may revoke this authorization at any time and must do so in writing to the Cleveland Vision Center.

_______________________________________________________________________________

Name of Parent or Legal Guardian (please print) Cell Phone Number

_______________________________________________________________________________

Signature of Parent or Legal Guardian Date

_______________________________________________________________________________

Staff Signature for Receipt of Verbal Authorization Date