UNACCOMPANIED MINOR AUTHORIZATION LETTER

Date: ________________

My signature below indicates that I, ________________________, give permission for my child, ________________________, to be examined on (date) ________________ by Dr. ________________________.

I am aware that I am financially responsible for any debt incurred. If any treatment is necessary, including eye drops, I understand that I will need to be present, even if this requires scheduling another appointment.

____________________ will be accompanying my child to the appointment and will have current insurance information, a photo ID (for themselves and my child) and payment for any expenses (co-pay/exam) incurred at time of service.

____________________
Parent/Legal Guardian Signature

Phone number(s) where I can be reached:

Home: ________________ Work: ________________
Cell: ________________ Other: ________________

Auth for Unaccompanied Minor 03-01-2019