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Eyesight Locations
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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