Virginia Eye Institute

AUTHORIZATION FOR THIRD PARTY TO CONSENT TO TREATMENT OF MINOR

I am the
_____Parent
_____Guardian
_____Other person having legal custody _____
(describe legal relationship)

of _____, a minor.
(name of minor)

I hereby authorize _____
(provide name(s) of caregivers)
to act as my agent(s) to consent to any examination, testing, anesthetic, or medical treatment which is recommended by, and to be rendered under the general or special supervision of, any licensed doctor at Virginia Eye Institute.

I understand that this authorization is given in advance of any specific diagnosis, treatment, or care being required, but is given to provide authority to the above-named agent to give consent to any and all such diagnosis, treatment or care which a licensed doctor recommends for the minor listed above.

These authorizations shall remain effective until _____, unless sooner
(month/day/year)
revoked in writing.

Signature:_____Date/Time:_____
(Parent/guardian/other person having legal custody)

Print Name:_____
(Parent/guardian/other person having legal custody)

Witness to Signature:_____Date/Time:_____

MINOR'S NAME:_____

_____copy given to Agent
Initials

_____original scanned to chart
initials