REDMOND VISION CLINIC
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Permission to Treat a Minor Without a Parent/Guardian Present

This form gives Redmond Vision Clinic legal permission to treat your child in case you cannot accompany him/her to the clinic for treatment. Consent may include, but is not limited to clinic visits, medical treatment and tests.

Patient (Minor's) Full name: _____

Patient's Date of Birth (*mm/dd/yyyy*): _____ /_____ /_____

A. I hereby authorize (caregiver name, i.e. grandparent, babysitter):

_____ relationship: _____
to give consent to any medical treatment by any licensed physician in the State of Washington for my child at Redmond Vision Clinic.

B. _____ (*please initial*) I authorize the minor to attend appointments, consent to treatment and for my child **to make health decisions with no adult present**.

_____ (*please initial*) This authorization shall remain effective until revocation in writing by the undersigned.

_____ (*please initial*) This authorization expires in ONE YEAR from the date signed.

In case of emergency, I can be reached at (_____) _____ - _____

I acknowledge that I am responsible for all charges in connection with the care and treatment rendered.

Signature: _____ Date: _____
(Parent or Legal Guardian)

Parent/Guardian Print Name: _____ relationship: _____