

Patient #: \_\_\_\_\_



## 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: \_\_\_\_\_  
(Parent or Legal Guardian)

Date: \_\_\_\_\_

Parent/Guardian Print Name: \_\_\_\_\_ relationship: \_\_\_\_\_