Dr. Bethany Harrington

Dr. Marc Hautot

Dr. Bonnie Keaton

Poplarville EYE CLINIC

Authorization to Consent to

Medical Treatment of Minor

Name: _____

D.O.B. : _____

I certify that I am the parent/ guardian of the person named above and hereby give consent for my minor child under the age of 18 to sign herself/himself in for her/his office visits at POPLARVILLE EYE CLINIC.

I give my full consent for my child:

- To be seen by provider without my presence
- To have additional diagnosing, testing, and treatment without calling me to discuss
- To have additional diagnosing, testing, and treatment but I must be called first to discuss

The telephone number(s) that I can be reached at all times is the following:

_____

I understand that I have had an opportunity to consider this consent and agree that all my questions and concerns have been answered. All blanks were filled in prior to my signature. This consent form is valid until revoked by me in writing.

_____ _____

Signature of Patient or Person Authorized to Relationship to Patient

_____

Date