Gadsden Eye Associates, P.C.

PARENT DELEGATION FORM

Patient's Name: _____

I authorize the following persons to present my child to Gadsden Eye Associates, P.C. for vision exams and medical care in my absence including pupil dilation, testing and procedures (unless otherwise indicated below.)

I give Gadsden Eye Associates, P.C. permission to provide these services during this and subsequent visits. I will notify Gadsden Eye Associates, P.C. in writing if I choose to modify or withdraw this authorization.

List any and all persons who have permission to present your child for treatment.

1. _____
2. _____
3. _____

Please list any treatment you do not want your child to receive without your prior written or verbal consent.

1. _____
2. _____
3. _____

_____ Date_____

Parent's Signature