



## Authorization – Non-Parent Guardian To Accompany Patient

Periodically there may be times when you are unable to bring your child to the office for an appointment and need to rely on a family member or friend. We understand these circumstances. However, we must have a written authorization letter allowing this person to accompany your child(ren). The person bringing your child will need to present a photo identification at the time of service.

This authorization gives the person permission to bring your child(ren) in, speak to the doctor, give authorization for treatment, medications, certain procedures and make general health decisions.

I (guardian print name) , \_\_\_\_\_, give the person(s) listed below permission to bring my child to Eye Surgical Associates or Sutton Linder Sutton and to discuss and share medical information about my child. I further authorize them to see all necessary medical records and make health care decisions of a routine nature as determined at the sole discretion of the provider. I am aware that I am responsible for any exam, testing, and procedure charges that are incurred during the visit.

I also give the authority to make more serious or urgent health care decisions in the event I cannot be reached or where it is of an emergency nature, where there is not sufficient time to seek out my specific consent.

Child's Name: (print name) \_\_\_\_\_ DOB: \_\_\_\_\_

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*(IF ONLY PARENTS ARE ALLOWED TO BRING CHILD IN, PLEASE INDICATE NONE)*

\_\_\_\_\_  
Name Of Person (allowed to bring child) Relationship to child

\_\_\_\_\_  
Name of Person (allowed to bring child) Relationship to child

\_\_\_\_\_  
Name Of Person (allowed to bring child) Relationship to child

\_\_\_\_\_  
**Signature (Parent/Guardian)** **Date**

**This Consent is valid for 12 months from the date signed.**