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Anak K. Shrestha, MD  
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J. Alan Eickelman, OD  
Cory W. Smith, OD  
Yvonne J. Morrissey, OD  
Sherry L. Shepherd, OD  
Brandon J. Tibbitts, OD

## CONSENT TO TREAT MINORS

David Aldag, Administrator

DATE: \_\_\_\_\_

MINOR PATIENT'S NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

I, \_\_\_\_\_, authorize the individual(s) (must be an adult over the age of 18) listed below to accompany the minor patient listed above to their appointment(s) at Rocky Mountain Eye Center and make any necessary medical decisions in their best interest at their eye care visit(s) until further notice.

Signature of Parent/ Legal Guardian: \_\_\_\_\_

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

Name(s) of Authorized Individual(s):

Relationship

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\_\_\_\_\_

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