Sreeni Basa, MD
Eric E. Blom, MD
Scott A. Butikofer, MD
Michael W. Coatney, DO
Benton F. Murphy, MD
Paul D. Rastrelli, MD
Donald A. Schlomer, MD
Anak K. Shrestha, MD
Nathan R. Stevens, DO

D. Mitchel Brown, OD
Nicholas J. Chariton, OD
J. Alan Eickelman, OD
Heather N. Kim, OD
Michael E. Millsap, OD
Yvonne J. Morrisey, OD
Cory W. Smith, OD
Brandon J. Tibbitts, OD

Scott Wilson, Executive Director

AUTHORIZATION FOR TREATMENT OF MINOR PATIENTS

If the parent or legal guardian will not be bringing the minor child to his/her appointment, we need written permission from the parent/legal guardian that we can see that child.

Complete the following information to authorize us to provide care for your child. By listing the individual(s) below, you authorize them bring your child to appointments and make any necessary medical decisions at their eye care visit(s).

This authorization will remain in effect until you notify Rocky Mountain Eye Center Inc. that you revoke the authorization or when the child turns 18 years of age. The authorized individual(s) must be 18 years of age or older.

DATE:_____

MINOR PATIENT'S NAME:_____ Date of Birth:_____

I AUTHORIZE the following individual(s) to accompany the minor patient listed above to his/her appointment(s) at Rocky Mountain Eye Center, Inc. and give the physicians and clinical staff permission to examine, instill drops and administer necessary medical care. I affirm that that the information below is correct, and that I am the parent/legal guardian of the above-mentioned patient.

NAME OF AUTHORIZED INDIVIDUAL:_____

RELATIONSHIP (TO CHILD):_____

NAME OF AUTHORIZED INDIVIDUAL:_____

RELATIONSHIP (TO CHILD):_____

PARENT/LEGAL GUARDIAN NAME: _____

SIGNATURE:_____

DAY-TIME PHONE NUMBER: _____

ALTERNATE PHONE NUMBER: _____

CONTACT INFORMATION OF ANOTHER PARENT/LEGAL GUARDIAN IF I AM UNABLE TO BE REACHED:

NAME: _____

RELATIONSHIP TO PATIENT: _____

DAY-TIME PHONE NUMBER: _____

ALTERNATE PHONE NUMBER: _____