KUMAR EYE INSTITUTE

Pediatric Ophthalmology Clinic

We realize that **Parents** or **Legal Guardians** may not always be able to personally bring their child(ren) to the office themselves. If a **Parent** or **Legal Guardian** can not be present, then anyone authorized below can accompany the child(ren) and give consent for treatment, which includes examinations and telephone medical advice.

This form **MUST** be completed by a **Parent** or **Legal Guardian**.

I, _____ the **Parent** or **Legal Guardian** of

_____ , _____ ,

_____ , _____ ,

_____ , _____ ,
(child's name) (child's name)

Give consent for the following people to have my child(ren) treated by Dr Ashima Kumar Gupta and staff:

Authorized People	**Relationship to Patient**	**Please Mark if Allowed to Discuss Financial Information**

Signature _____ Date / /

ANNUAL AUTHORIZATION RENEWAL

Initial _____ Date / /

Initial _____ Date / /

Initial _____ Date / /