DESIGNATION OF ANOTHER PERSON TO CONSENT TO TREAT MINOR CHILDREN

I, (parent/legal guardian) _____ cannot accompany my

child (child's name & date of birth)

_____, to The Eye Institute of

West Florida.

Therefore, I give permission to (person's name and relationship to the minor)

_____ as follows (check one):

_____ I give permission for this person to seek medical treatment, including any type of in-office procedure, and provide consent for such treatment if attempts to contact me are unsuccessful.

_____ I give permission for this person to seek medical treatment, including any type of in-office procedure, and provide consent for such treatment without having to contact me.

Expiration of Permission (check one):

_____ This form will remain effective until revoked by filling out the Notice of Revoke "Designation of Another Person to Consent to Treat Minor Children" Form.

_____ This form is VALID ONLY during the following timeframe:

Effective date: _____ / Expiration date: _____

X_____ _____

(signature of parent or legal guardian) Date signed (required)

X_____ _____

(signature of witness – 18 years of age or older) Date signed (required)