



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)

LARGO

1225 West Bay Drive
Largo, FL 33770
(727) 581-8706

CLEARWATER

3220 McMullen Booth Rd
Clearwater, FL 33761
(727) 723-8706

ST. PETERSBURG

6133 Central Ave
St. Petersburg, FL 33710
(727) 344-3008

HYDE PARK

501 N. Howard Ave, Ste 100
Tampa, FL 33606
(813) 253-2727

WESTCHASE

11925 Sheldon
Road
Tampa, FL 33626
(813) 792-0444