Consent to Treat a Minor

I give consent for ***North Georgia Eye Care/ Dr. Robison*** to treat

_____ _____

PRINT NAME OF MINOR **DATE OF BIRTH**

I understand the following:
1. This consent will remain active until revoked in writing or when the patient reaches the age of maturity (18).
2. Attempts will be made to contact me (or my representative present at the time) to discuss any fees before orders are placed, or any additional services beyond the basic glasses exam.
3. Permission to dilate at each exam, when needed.

By signing this form, I am stating that I am responsible for health care decisions of this minor.

_____ _____

PRINT NAME **RELATIONSHIP TO PATIENT**

_____ _____

SIGNATURE **TODAY'S DATE**