Authorization to Treat Minor Patient in Absence of Parent/Guardian

I, _____ (name of parent/guardian), the legal guardian of _____ (name & date of birth of child), hereby authorize _____, (name of adult accompanying child to office) to accompany my above-named child to office visits with _____ (name of physician/physicians) and to consent to the examination and/or treatment of my child during the office visits.

I reserve the right to revoke this authorization at any time by writing to the above named physician. I understand that my child (under 18 years of age) cannot attend his/her appointment without the accompaniment from the adult listed above.

Authorization to see and treat Minor child under the age of 18 NOT accompanied by an adult:

I give consent to Associated Eye Care, Associated Eye Care Opticians, or the Ambulatory Surgery Center to provide the necessary or requested services for treatment of this patient. This also includes all visits necessary for the fitting and follow-up of contacts or glasses.

This authorization:

- ☐ Is effective only on _____(month/day/year) **OR**
- ☐ Is effective from _____ to _____ month/day/year. **OR**
- ☐ Is effective until revoked by me in writing

** Insurance Cards and Co-Payments- Please make all necessary arrangements to have insurance cards and Co-payments available at the time of the visit.

_____ _____ _____

Signature of Parent/Guardian Date Phone number where you can be reached

Emancipated Minor Exception for Minnesota

MINN. STAT. § 144.341 – MINOR PATIENTS LIVING APART FROM THEIR PARENTS

A minor patient who is living separate and apart from his or her parents or legal guardian, whether with or without the consent of a parent or guardian, and who is managing his or her own personal financial affairs, may give effective consent to personal medical, dental, mental and other health services. Pursuant to Minn. Stat. § 144.345, the consent of a minor who claims to be able to give such consent, but who may not in fact be able to do so, will be deemed effective if the health care provider relied in good faith on the representations of the minor patient.

CONSENT BY MINOR CLIENT – MINNESOTA OFFICES ONLY

_____ I am an emancipated minor.

I declare under penalty of perjury that the above information is true and correct.

_____ _____

Signature of Minor Date