MEDICAL AUTHORIZATION FORM

I, _____, cannot accompany my

child/children _____ to Coley

and Coley Eyecare.

- ☐ I authorize the following adult _____ to make decisions regarding any tests/treatments they feel necessary to help the child's vision, and to make payments for the child.

- ☐ I authorize the minor (16 or over) to drive themselves. I authorize Coley and Coley Eyecare to perform any tests/treatments they feel necessary to treat the patient. I authorize the patient to make payments for their examinations and glasses/contact lenses necessary to improve vision.

A photocopy of this authorization shall be deemed effective as if it were an original. This authorization shall remain in effect until revoked.

_____ _____

PARENT OR LEGAL GUARDIAN DATE