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PREAUTHORIZATION TO TREAT MINORS

For families who are ongoing patients at Olson Eye Care it may be more convenient to have prior authorization for medical care delivered directly to minors without a parent having to be present prior to treatment. Please review the following authorization for treatment and complete the information if you want to authorize such treatment in advance.

I (we) request and authorize Olson Eye Care and its personnel to deliver medical care to my (our) child(ren) listed below:

NAME: _____

DATE OF BIRTH: _____

NAME: _____

DATE OF BIRTH: _____

NAME: _____

DATE OF BIRTH: _____

Please try to contact me (us) regarding health care of my (our) child(ren) at the following phone number(s):

PARENT/GUARDIAN'S NAME: _____

PHONE: _____

PARENT/GUARDIAN'S NAME: _____

PHONE: _____

OTHER (RELATIONSHIP): _____

PHONE: _____

Signature: _____ Date: _____

Print name and relationship: _____

NOTE: IF there are any special parental or custodial relationships (such as custody with one parent only, legal custody/guardianship with non-parent, etc.) please explain in the space below with your signature, printed name, and phone number at which you can be contacted.

Parent/Guardian Printed Name:

Parent/Guardian Signature:

Phone Number:
