KIRK EYE CENTER

PERMISSION TO TREAT

I, the undersigned, ___ parent___ legal guardian, do hereby give Kirk Eye Center physicians permission to treat_____, my____ child ____ ward, for any vision or other problems related to his/her eyes using whatever ophthalmic treatments that Kirk Eye Center provider deems medically necessary. This may include tests that are needed for the diagnosis of the condition for which the patient is being seen. This permission is valid for one year from this date, or until _____, _____, which date is less than one year from the date below.

I also authorize the following individuals to access my ___child's ____ward's medical records.

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

I further authorize the release of my ____child's ____ ward's medical record information for purposes of obtaining payment or any further treatment necessary.

Financial Responsibility

_____ shall be financially responsible for any charges related to this visit, and any subsequent visits, until the expiration date specified above. This will be accomplished by billing the insurance plan or individual as specified above.

Signature of Parent or Guardian_____