Permission to Treat
Kirk Eye Center

Patient Information:

- Account #: _____
- Minor Child's Full Name: _____
- Date of Birth: _____
- Address: _____
- City, State, Zip: _____
- Phone Number: _____

Parent/Legal Guardian Information:

- Parent/Legal Guardian Name: _____
- Relationship to Child: _____
- Address (if different): _____
- Phone Number: _____
- Email: _____

Authorization for Treatment:

The undersigned, _____ is the parent or legal guardian of the minor child named above. The undersigned has the legal right to consent to medical treatment for this patient. Kirk Eye Center is authorized to provide optometric care and treatment to the minor child, including:

- Routine eye exam including refraction
- Dilation of pupils
- Contact Lens fitting/training

Insurance/financial consent on the following page:

Financial and Insurance Information:

The parent/guardian understands that they are financially responsible for all medical expenses incurred by the child during these appointments. They agree to pay any copayments or fees for professional services at the time they are rendered.

- Insurance Provider: _____
- Insurance Policy Number: _____
- Group Number: _____
- Please send the insurance card and copay (if applicable) to the appointment with the patient.

Authorization for Information Disclosure:

It is understood that the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable State laws govern the disclosure of Protected Health Information (PHI). Kirk Eye Center is authorized to disclose the minor child's PHI to the Parent/Legal Guardian listed above.

Duration of Consent:

This authorization is effective from the date signed below through patient's scheduled appointment this year. A new consent form would be required at the minor child's next appointment.

Signature:

_____

Parent/Legal Guardian Signature/Date

_____

Printed Parent/Legal Guardian Name

Note: A photocopy of this signed form is considered as valid as the original