ILLINOIS eye CENTER
Your Vision Empowered

Patient Name _____

DOB _____

Account No. _____

CONSENT FOR MEDICAL TREATMENT OF A MINOR

AUTHORIZATION

I appoint the adult over 18 years of age listed below to consent to any necessary examination, anesthetic, medical diagnosis, medication treatment, and / or treatment to be rendered to the above-named minor under the care of any Illinois Eye Center doctor or staff. I understand this may require the sharing of protected health information concerning my child with the adult named below.

Name: _____

Address: _____

Relationship to the child: _____

☐ By checking this box, I grant my preauthorization allowing Illinois Eye Center to care for my minor child without a parent, legal guardian, or another adult present.

SIGNATURE – SIGN IN THE PRESENCE OF ILLINOIS EYE CENTER STAFF OR NOTARIZE

Print Parent Name: _____ Phone: ( )

Parent Signature: _____ Date: _____

**If signed by a Legal Representative, Relationship to Patient: _____

Print Witness Name: _____

Witness Signature: _____ Date: _____

NOTARIZATION:

I, the undersigned, a Notary Public, do hereby certify that the persons whose names are subscribed to the foregoing instrument appeared before me this day in person and acknowledged that they signed and delivered the foregoing instrument as their free and voluntary act for the purposes set forth therein.

Given under my hand and seal this ____ day of _____, 20_____.

Notary Signature: _____

REVOCATION OF AUTHORIZATION

This authorization is valid until I revoke it in writing. If the date field below is blank, this authorization continues to be valid.

This authorization is revoked as of Today's Date: _____

Please return to:
Illinois Eye Center Attn: Medical Records
8921 N Wood Sage Road
Peoria, IL 61615

Fax: (309) 243-7918
Email: Medicalrecords@illinoiseyecenter.com
Phone: (309) 243-2400