MIDWEST EYE CARE, P.C.

PREAUTHORIZATION TO TREAT MINORS

For families who are ongoing patients of Midwest Eye Care, P.C. 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.

AUTHORIZATION

I (we) request and authorize Midwest Eye Care, P.C. and its personnel to deliver medical care to my (our) child(ren) listed below:

NAME: ____
DOB: ______________________________

NAME: ____
DOB: ______________________________

NAME: ____
DOB: ______________________________

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

PARENT'S NAME: ____
PHONE (OFFICE/HOME):_______________________________________

PARENT'S NAME: ____
PHONE (OFFICE/HOME):_______________________________________

OTHER (RELATIONSHIP):____
PHONE (OFFICE/HOME):_______________________________________

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.

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