



Main Office  
250 Avenue K, SW Suite 200  
Winter Haven, FL 33880  
863/297-5400  
800/472-8867 Toll Free

**AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL  
GUARDIAN(S)**

I do hereby solemnly swear that I have legal custody of the aforementioned minor child.

I grant my authorization and consent for \_\_\_\_\_ (hereafter "Supervising Adult")

to accompany my child \_\_\_\_\_

for an evaluation by any of the physicians at the Center for Retina and Macular Disease. If it is determined by the physician that a medical treatment is required for my child, I authorize the Supervising Adult to issue consent for any treatment to be rendered under the general supervision of any of the duly licensed physicians of the Center for Retina and Macular Disease.

It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power on the part of the Supervising Adult in the exercise of his or her best judgment upon the advice of any such medical or emergency personnel.

By affixing my signature below, I do hereby agree to hold harmless and indemnify the Center for Retina and Macular Disease and all agents and representatives thereof (the releases) from all claims of losses, injuries, and damages that may be the result of any treatment. I further agree to waive any sights of legal action against the said releases.

This authorization is effective commencing on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ and expiring on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_.

\_\_\_\_\_  
Parent #1's Signature

\_\_\_\_\_  
Parents printed name

I, \_\_\_\_\_, swear and attest that the signature of the above parent is indeed the legal signature of the parent as witnessed by myself on this day.

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name