OPHTHALMOLOGY
ASSOCIATES OF GREATER ANNAPOLIS

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PERMISSION FOR VISIT/TREATMENT OTHER THAN PARENT

Please use this form if someone other than the parents or legal guardian are bringing your minor child for an exam.

Date: ____________________

Patient name: ____________________________________

Parents name: ____________________________________

Best number to contact you during the day: ____________________

I, __________________________________ give permission for
(parents name)

_____________________________, to bring my child, ____________________
(name and relationship) *(child's name)*

to Ophthalmology Associates of Greater Annapolis to be examined and treated by Dr. John M. Avallone, Dr. Kollias or Dr. August Pasquale for their eye care needs.

Parents Signature: ____________________________________

This permission expires: ____________________________