little eyes
Pediatric Eye Care & Adult Strabismus
3801 W. 15th St., Suite A-110
Plano, TX 75075

Becky Luu, OD, FAAO

Consent for Procedure/ Treatment of a Minor Child

I authorize and direct Dr. Becky Luu OD, FAAO and her assistants as necessary to perform quality care, procedure/treatment(s) upon my minor child.

Patient Name:_____ DOB: _____

This authorization is good until we receive any other formal written requests to remove authorized persons or will end on this date _____.

The person(s) authorized to request treatment on my behalf is/are:

(1)_____ Relationship to patient _____

(2)_____ Relationship to patient _____

Patient or Legal Guardian Signature: _____ Date:_____

Please Note:

- **Signature of parent must match the signature on file in our office**
- **If a patient has never been seen in our office a copy of driver license must be attached**
- **If legal guardian is signing a copy of guardianship papers must be on file in our office**

Please email this completed form and driver license to info@littleeyesplano.com