LODESTAR
FAMILY EYE CARE, PC

Consent for Care

Dr. Frank / Dr. Reynolds has my consent and permission to provide medical/vision care, including any diagnostic drops to _____ in my absence. I understand that if I am not present to make decisions, Drs. Frank and Reynolds will act in the best interest of the patient, and may need to perform specialty testing or dilation in order to determine the most appropriate diagnosis and treatment plan. This consent is valid until there is a change in status of legal guardianship, or until I otherwise specify in writing.

_____ _____

Patient's Signature / Authorized Person to Sign for Patient Date

_____ _____

Doctor / Witness Signature Date