PARENTAL—PATIENT UNDER 18 RELEASE TO BE SEEN WITHOUT PARENT/GUARDIAN PRESENT

Medical Eye Specialists
300 North Willson, Suite 1003, Bozeman
205 West Main Street, Belgrade
422 South Main Street, Livingston
406-587-1245

Patricia A. Cosgrove, M.D.
Wesley H. Adams, M.D.
Joseph P. Sheehan, M.D.

Lisa A. Herrygers, M.D.
Kristy L. Moeller, M.D.
Karen S. Shimshak, M.D.

I, _____ _____,
Patient Parent — Date of Birth

hereby give permission for my child: _____

_____**to be seen without my being present by:**
Date of Birth

_____ **on this date** _____.
Doctor's Name

I understand that my child may be dilated and that this may affect his/her driving abilities.

_____ _____
Patient Signature — Witness Signature

_____
Date