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


## Helena Eye Clinic

3116 Saddle Drive, Suite 3
Helena, MT 59601
Office: 406-443-4040
Fax: 406-443-0773


**I,** _____
Patient Guardian

**hereby give permission for my child:**

_____
_____,
Patient Date of Birth

**to be seen without me being present by:**

_____,
Doctor's Name

**on this date** _____.

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

_____
_____
Patient Signature Witness Signature

_____
Date