



**CARL E. FLINN, MD**  
 PEDIATRIC OPHTHALMOLOGY & ADULT STRABISMUS  
 773 Estate Place  
 Memphis, TN 38120  
[www.carlflinnpeepers.com](http://www.carlflinnpeepers.com)  
 901-681-4040 (p) 901-681-4052 (f)

**CONSENT TO MEDICAL TREATMENT FOR A MINOR**

Today's Date: \_\_\_\_\_

I, \_\_\_\_\_, (parent/guardian) grant permission to  
 \_\_\_\_\_ (adult accompanying patient), to make medical  
 decisions regarding the treatment of \_\_\_\_\_ (patient). The  
 aforementioned adult has my permission to discuss medical treatment plans and actions and provide  
 necessary medical history with Dr. Flinn and his staff. This letter will be valid for one year from  
 \_\_\_\_\_ (mm/dd/yy).

Patient's Name: \_\_\_\_\_ Patient's DOB: \_\_\_\_\_

Parent/Guardian's Printed Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Parent/Guardian's Signature: \_\_\_\_\_

Valid phone number that our office can use if we need to contact the above parent/guardian:

\_\_\_\_\_

Please include this form with the completed paperwork packet on our website. If the paperwork is not complete in full, we will not be able to see the patient. The adult listed above accompanying the patient must also have a valid ID and be prepared to make any payments due at the time of the visit. If you have any questions, please call our office at the number listed above.