specs EYE CARE Casey N. Roland, OD

AUTHORIZATION TO PERFORM MEDICAL SERVICES TO A MINOR

I, _____ hereby authorize Dr. Casey N. Roland, OD to provide medical services to include:

☐ Comprehensive Eye Exam
☐ Contact Lens Exam
☐ Dilation of the Pupils
☐ Any treatment found medically necessary by said physician

to my minor child _____ without my required presence during the eye exam on _____.
This authorization for medical care is valid until further written notice provided by me.

_____ _____
Parent/Legal Guardian Signature Witness

_____ _____
Date Date

Casey N. Roland, O.D.
Specs Eye Care
4409 Evans to Locks Rd
Evans, Ga 30809
706-396-7671