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By signing this form, I, _________________________________ (**print patient name**), am giving authorization to ____ (**print name**) at ____________________________ (**phone number**) , my _____________________________ (**relationship to patient**), to schedule my appointments with this office, discuss my medical situation with the doctor and technicians, and discuss all surgical and financial information with the appropriate staff at Mitchell & Morin Eye Institute.

Patient name: ____ (**print name**)

Signature: ____

Authorized person's name: ________________________________ (**print name**)

Relationship to patient: ___________________________________

Signature: ____

Witness: ____

Date: ___________________