Designation of Another Person to Consent for Treatment of a Minor Child

Minor Child Full Legal Name: ___________________________________Date of Birth: __________________

Parent/Legal Guardian Full Legal Name: ____
Telephone:_________________________________ Relationship to Minor Child: ________________________

Parent/Legal Guardian Full Legal Name: ____
Telephone:_________________________________Relationship to Minor Child: ________________________

If a parent/legal guardian cannot accompany a minor child to his/her appointment, please use the following lines to designate who has permission to accompany the child. Examples may include grandparents, neighbors, nannies, or siblings over 18 years of age.

Designated Adult Full Legal Name: ____
Home Address: ____
Telephone:_________________________________Relationship to Minor Child: ________________________

Designated Adult Full Legal Name: ____
Home Address: ____
Telephone:_________________________________ Relationship to Minor Child: ________________________

Designated Adult Full Legal Name: ____
Home Address: ____
Telephone:_________________________________ Relationship to Minor Child: ________________________

I, ________________________, am the parent or legal guardian of _____________________ ("Minor Child"), who is not emancipated and under age 18. By signing this form, I authorize the above listed Designated Adult(s) to consent to or refuse any eye care or treatment for Minor Child that is recommended by Pediatric Ophthalmology and Strabismus, including minor surgical procedures. I understand that my authorization is given prior to any ocular treatment or recommendation. This authorization empowers Designated Adult(s) with authority to exercise his/her best judgment upon the advice of Pediatric Ophthalmology and Strabismus, and consent to or refuse any eye care or treatment for Minor Child.
I retain the responsibility for all financial obligations owed to Pediatric Ophthalmology and Strabismus resulting from Designated Adult's consent.
I release Pediatric Ophthalmology and Strabismus, providers, and staff from any liability arising from this form and Designated Adult's consent to or refusal of treatment for Minor Child.
I understand that the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable State laws govern the disclosure of Protected Health Information (PHI). I authorize Pediatric Ophthalmology and Strabismus to disclose Minor Child's PHI to the Designated Adult(s).

My authorization is effective until Minor Child reaches age 18, or until I revoke my authorization by completing Pediatric Ophthalmology and Strabismus' "Notice to Revoke" form.

Parent / Legal Guardian Signature: ____________________________________ Date: ________________