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

Minor Child Full Legal Name: _____Date of Birth:_____

If a parent/legal guardian cannot accompany a minor child to his/her appointment, please use this form to designate who will accompany the child. This form is necessary for step-parents, grandparents, siblings over 18 years, nannies, etc.

Parent/Legal Guardian Full Legal Name: _____
Telephone:_____ Relationship to Minor Child: _____

Parent/Legal Guardian Full Legal Name: _____
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 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. However, this authorization empowers Designated Adult 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 charges by 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 Designated Adult.

My authorization is effective until Minor Child reaches age 18, or until I revoke my authorization in writing.

Parent / Legal Guardian Signature: _____ Date: _____

I authorize my unaccompanied minor child, who is at least 16 year of age, to consent to or refuse treatment that is recommended by Pediatric Ophthalmology and Strabismus in my absence. I understand that my child may need his/her eyes dilated during the examination and give consent that my child may drive him/herself home from the appointment.

Parent / Legal Guardian Signature: _____ Date: _____

Cc: admin/HIPAA/designation of another person…040717