WesternU Health | Pomona
Eye Care Institute

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# Consent for Treatment of Minor Child

By completing this form, it will authorize an alternate decision maker to consent to, and be involved in, Medical treatment services and care of your minor child here at the Western University Eye Care Institute.

Minor Child's Name _____

Date of Birth _____ Age _____

I authorize Western University Eye Care Institute to provide the following treatments:

- ○ Physical Examination
- ○ Administer Immunizations
- ○ Treat wounds
- ✔ Other EYE EXAM_____

___ **Direct authorization for care/treatment.** I authorize Western University Eye Care Institute to provide the above named minor child with emergency, urgent and other Medical care and treatment in my absence.

___ **Designation of Parent Substitute to authorize care/treatment for minor child.** I authorize the Parent Substitute designated below to give informed consent for emergency, urgent and other Medical treatment for the Minor child.

___ **Identification of Parent Substitute.** I appoint the following individual(s) to obtain access to Protected Health information, give informed consent for Medical treatment, or otherwise receive custody of the Minor Patient.

_____

Name/Relationship Address

___ **Duration of authorization.** This consent is valid for one (1) year beginning on _____, 20____ and expiring on _____, 20 ____. This authorization may be revoked by me at any time prior to that expiration date by providing Western University Eye Care Institute with written notice.

___ **Release of Information.** To ensure that the Parent Substitute has access to Protected Health Information needed to make informed consent decisions, I authorize Western University Eye Care Institute to provide the above named Parent Substitute with Protected Health Information relating to the Minor child only. "Protected Health Information" means all Medical records relating to the Minor child which are protected and confidential as is defined by HIPAA/HITECH, and include: account information, appointments, and treatments planned or given. I also agree to release Western University Eye Care Institute and the providers from liability for any claims resulting from release of Protected Health Information in reliance upon this authorization.

I have carefully read and considered this consent for before signing it.

**SIGNATURE OF PARENT OR LEGAL GUARDIAN:**

_____ _____
Signature (specify parent or guardian) Date

_____ _____
Signature of Witness Date

**CONTACT INFORMATION For Parent or Legal Guardian:**

Name:_____

Mailing Address:_____

Home Phone Number:_____ Cell Phone Number: _____

Work Phone Number: _____ Other Contact Information: _____

**A signed electronic copy of this form is as valid as the original.**