Ideal EyeCare
OPHTHALMOLOGY

CONSENT TO EXAMINE/TREAT MINOR CHILD

I certify that I am the parent/legal guardian of _____, a minor child, and I give Dr. Grace Shin and the clinical staff at Ideal EyeCare permission to examine, instill eye drops, and administer necessary tests to my child outside of my presence. I attest that the individual escorting my child to his/her appointment is 18 years of age or older and is capable of making medical decisions with regard to my child's care. I authorize _____ to accompany my child to his/her visit as I am unable to personally attend the appointment. I consent to add this person as an approved HIPAA contact and understand that he/she will have access to my child's PHI until I provide written revocation.
I understand that I am financially responsible for services rendered to my child in my absence and I may request a written summary of the visit if I have any questions about his/her condition and recommended treatment. I understand that I may be asked to provide a new form for each visit I am unable to attend.

Patient's Name: _____

Patient's DOB: _____

Appointment Date: _____

Escort's Name: _____

Escort's Relationship to Child: _____

Escort's DOB: _____

Escort's Phone Number: _____

I understand that I may be contacted to confirm the information provided on this form and that the staff at Ideal EyeCare may cancel or reschedule the appointment if they are unable to verify the identity of the individual accompanying my child.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

Contact Phone Number: _____

Alternate Phone Number: _____

Office Use Only

_____ Staff Initials

Notes: _____

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