AUTHORIZATION FOR TREATMENT OF MINOR LACKING CAPACITY OF CONSENT

This document will authorize Aurora Eye Clinic, Ltd, its physicians, clinical and administrative staff to provide medical care including an examination, medical diagnosis, treatment, imaging and other ancillary testing to:

_____, a minor whose date of birth is _____
(Patient's Legal Name) (Patient's DOB)

I _____ am either the Parent, Legal Guardian or Person having legal custody of the Patient and have discharged this responsibility

to_____who is accompanying my child.
Name of person bringing child

I understand the medical diagnosis and discussion of my child's treatment plan will be provided to this individual. I authorize and provide express consent to the Aurora Eye Clinic Physician(s) and/or its personnel to examine my child make clinical decisions and/or provide medical treatment even though I am not present.

This Authorization for Treatment will remain in effect indefinitely, unless I revoke such authorization in writing.

I agree and understand that any expenses incurred will continue to be the responsibility of the party signing this Authorization for Treatment Form, and that payment may be due upon completion of the visit depending upon my medical insurance coverage

Signature: _____
Parent/Legal Guardian/Person having legal custody

Print Name: _____
Print name of Parent/Legal Guardian/Person having legal custody

Date: _____

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