FAGADAU HAWK & SWANSON M.D. | Vision. For Life.

PREAUTHORIZATION TO TREAT MINORS CONSENT FORM

DATE OF SERVICE: _____

FOR FAMILIES WHO ARE ONGOING PATIENTS OF:

_____

(Pediatrician or Health Care Facility)

It may be more convenient to have prior authorization in place so that medical care may be delivered directly to minors if a parent or legal guardian cannot be present prior to treatment. Please review the following authorization for treatment and complete the information if you want to authorize such treatment for your minor child(ren) in advance. Be advised that protected patient health information may be shared with the proxy to whom the right to consent has been delegated to facilitate informed decision making.

AUTHORIZATION

I (we) have the legal right to preauthorize this facility to deliver medical treatment to my /our child(ren).

I (we) request and authorize_____ (ophthalmologist and/or contact lens specialist in the healthcare facility)

And its personnel to deliver medical care to my (our) child(ren) listed below:

Name: _____DOB: _____
Name: _____DOB: _____

LIMITATIONS OF TREATMENT (choose one):

_____ I do not want to limit the type of treatment. I will let the ophthalmologist decide what treatment my child needs that day. The providers of care will **NOT** do any procedure(s) without the presence of a parent or guardian.

_____I want to limit the treatment. The ophthalmologist cannot:
_____

PLEASE CONTACT ME IF YOU HAVE QUESTIONS

I want you to call me if my child has a serious condition.

Parent Name: _____ Cell Phone: _____

EXECUTED BY: _____ DATE: _____
(Parent or Legal Guardian)

This consent form will expire 90 days from date of service