Ohio Eye ASSOCIATES

466 S. Trimble Road
Mansfield, OH 44906-3482
419.756.8000 • 800.423.0694
www.OhioEyeAssociates.com

CAREGIVER AUTHORIZATION CONSENT TO TREATMENT

By law, any child under the age of 18 years old cannot be seen by a healthcare provider without consent from a parent or legal guardian. There are times when a minor patient may be in the care of an adult who is not the parent/guardian. A parent may give written authorization to another adult to consent to a surgical or medical procedure or course of procedures for the parent's minor child pursuant to ORC 2317.54 (C)(2). You must complete a separate authorization for each minor patient and for each adult caregiver.

Minor Patient's Name ______________________________ DOB ______________

HEALTH INSURANCE INFORMATION ☐ No change since last visit *(skip to next section)*

Insurance Company ______________________ Policy Holder ______________________

ID Number ______________________ Group Number ______________________

Effective Date ______________________

AUTHORIZATION

I (parent/legal guardian name) ______________________ hereby authorize ______________________ (adult caregiver legal name), ______________________ (relationship) ("Caregiver"), to give Ohio Eye ("Ohio Eye") and its medical providers consent to surgical or medical procedures or a course of medical procedures for my child named above ("Minor Patient") as may be deemed necessary or advisable in the diagnosis and treatment of the Minor Patient by Ohio Eye providers, with the exception of any limitations listed below. I am also aware that I am responsible for payment of the patient portion of any charges at the time of service. I hereby authorize Ohio Eye to process charges for services provided to Minor Patient.

I have the legal right to authorize Caregiver to give Ohio Eye consent to medical and surgical procedures for the Minor Patient. I understand that I may revoke this Authorization at any time in writing.

Federal law does not allow Ohio Eye to disclose any protected health information (PHI) to Caregiver unless the parent/guardian appoints him or her as their child's "personal representative". Therefore, I hereby appointment Caregiver as Minor Child's personal representative and authorize Ohio Eye to release Minor Patient's PHI to Caregiver. I may revoke this appointment at any time. My revocation will NOT affect any actions that have been already taken in reliance on this document.

I have read, understand, and give my authorization as stipulated above. My signature indicates that I have read this form and/or have had it read to me and explained in the language that I can understand.

LIMITATIONS

Identify any specific limitations on the kinds of medical services and PHI for which this authorization is given. (If none, state "none"):

____

____

This consent shall be in effect until: ☐ Date ______________ ☐ Indefinitely, until revoked by written notice.

____
Parent or Legal Guardian (please print) Relationship

____
Parent or Legal Guardian Signature Date