MRN#_____

BLUE SKY VISION EYE CARE, P.C.
PARENTAL CONSENT FOR MEDICAL TREATMENT OF A MINOR

Minor Child's Information

Full Name:_____

Date of Birth:_____

Parent/Legal Guardian Information

Full Name:_____

Relationship to Minor:_____

Phone Number:_____
(*for contact in case of emergency*)

CONSENT OF PARENT OR GUARDIAN:

- I, the undersigned, am the parent or legal guardian of the above-named minor. I hereby authorized BLUE SKY VISION EYE CARE, P.C. and its healthcare providers to provide medical evaluation, diagnosis, treatment, and procedures that may be deemed necessary or advisable for the care of my child. This includes, but not limited to, routine medical examinations, diagnostic tests (e.g., laboratory work, imaging), medical and/or surgical treatment, and emergency care. I understand that in the case of a medical emergency, efforts will be made to contact me as soon as possible. However, if I cannot be reached, I authorize Blue Sky Vision Eye Care, P.C. to proceed with the necessary treatment.

- I know that I have the right to consent or refuse to consent to any future care for my child and to discuss this care. The healthcare provider will discuss with my child and obtain specific consent. Invasive procedures and special treatments may require additional consent.

- I acknowledge that I have received or have had the opportunity to receive the Notice of Privacy Practices for Blue Sky Vision Eye Care, P.C. I authorize the use and disclosure of my child's protected health information ("PHI") as may be necessary or advisable for treatment, payment, and healthcare operations in accordance with the federal Health Insurance Portability and Accountability Act ("HIPAA") and applicable state law.

- I understand that:
    - This authorization is voluntary.
    - I have the right to revoke this consent at any time.
    - Revocation will not apply to information already disclosed or actions already taken.

- This authorization shall remain in effect until (select one)

_____ Until revoked in writing OR _____/_____/_____ (specific date)

_____ Date:_____
Signature of Parent or Guardian

Doctor Approval Initials: _____